Health Workplace Opportunities,
Resources and Challenges for
Saskatchewan

Job Satisfaction, Retention, Recruitment and Skill Mix for a Sustainable Health Care System

Report to the Deputy Minister of Health for Saskatchewan

Allen Backman, M.Sc., Ph.D.
September 2000

Table of Contents

Letter of Transmission 5
  To Glenda Yeates, Deputy Minister of Health 5

Introduction 7
  Forward 7
  Terms of Reference 8
    Research Project — Workplace Opportunities Resources And Challenges For Saskatchewan 8
  Definitions 9
    Values 9

Executive Summary 11
  What We Learned 11
    Purpose 11
    Front Line Provider and Supervisor Discussion Groups 11
    Regulators, Unions and Professional Associations 12
    Senior Management Teams 12
  Summary of Recommendations 13

Methodology 19
  Overview 19
    Discussion Group Design 19
    Analysis 22
  Key Informant Interviews 23

What We Read 27
  Literature Review 27
    How Do You Create Job Satisfaction? 27
    Multiskilling (Cross-Training) and Skill Mix 28
    The Labour Market 33
    Nursing Skill Mix 37
    Magnet Hospitals 38
    Typical responses to recruitment and retention difficulties 40

What We Heard 43
  Front Line Providers and Supervisors 43
  Challenges to Recruitment and Retention 43
    How the work is organized 43
    How the workplace is managed 49
    How the external environment affects the workplace 51
    Addressing Challenges to Recruitment and Retention 52
    Summary 53
  Unions and Regulators 54
    Skill Mix and Redistribution of Work 54
    The organization of work 55
    Perceptions Regarding Management 56
    Perceptions Regarding Government 57
    Perceptions Regarding Health Reform 57
    Workload Issues 59
    Casualization of the Work Force 60
    Recruitment and retention strategies 60
    Other Issues 62
  Senior Management Teams 62
    Workload Measurements 62
    Staffing 63

Workload 64
Recruitment and Retention 65
Staff Mix and Skill Mix 69
Collective Agreements and Management Rights 71
Structuring Work 73
Perceptions of the Health Care System Environment 73

What we Learned* *76
Recommendations for Change 76
Findings 77
Recommendations 78

References* *90

Appendices* *95
Appendix A. 95
Health Districts Included in Discussion Groups 95
Appendix B. 96
Discussion Group Participants 96
Appendix C. 97
Participant Consent Form 97
Appendix D. 99
Facilitation Guide 99
Appendix E. 106
Discussion Groups: Categories of Analysis—Challenges to Recruitment and Retention 107
Appendix F. 108
Discussion Group Participants' Recommendations for Addressing Challenges to Recruitment 108
Discussion Group Participants' Recommendations for Addressing Challenges to Retention and Job Satisfaction 110
Acknowledgements 112

Chapter 1

Letter of Transmission

To Glenda Yeates, Deputy Minister of Health

Dear Deputy Minister:

We are pleased to transmit the findings and recommendations of the Health WORCS Project. I thank you for having entrusted this important challenge to my team and me. Your Department provided every assistance I requested.

The major stakeholders within the system including health districts, unions and professional regulatory bodies rose to the task of aiding in this exploratory research. Health Districts and their affiliate agencies willingly accepted the expense of sending management teams to meet with us and provided resources to free their employees to participate in discussion groups. Unions and regulators took time to meet with us, sometimes repeatedly, and provide us with ancillary materials. Many of the stakeholders within the system provided us with written submissions.

Health WORCS has consulted with the Department of Health as to appropriate outcomes that would be useful from a policy point of view. Your Department has asked for several outcomes:

- The overall outcome desired by policy makers for any intervention is to improve health outcomes for the people of Saskatchewan. It is believed that the encouragement of high quality health care workplaces can have an impact on the quality of care provided to patients and clients.
- The subsidiary desired outcome is to improve the quality of the workplace. The healthy workplace involves much more than traditional occupational health and safety issues. It includes such notions as satisfaction and well-being.
- In order to encourage healthy workplaces, government needs a clear identification of the issues that adversely affect workplace health

An additional outcome desired by policy makers is the development of strategies that will address the workplace issues identified by Health WORCS. I hope that the research reported here and the recommendations derived from that research will prove useful to you.

I would also like to acknowledge the contributions of HSURC to whom portions of the research were subcontracted and who proved to be superb partners. My interactions with, its Board, its CEO, Laurie Thompson, and its staff, especially Senior Researcher Joanne Hader, were always positive and helpful.

In submitting my recommendations, I have one primary reservation. I have concluded that the problems of employee satisfaction, retention, recruitment and skill mix are multi-factorial and have no easy solutions. Indeed, some of the contributing factors are global or historical and are not amenable to actions that individual governments or organizations can apply. In addition, some of the issues defy understanding and require further research. Nonetheless, I hope that the recommendations I have been able to make will, if implemented, alleviate the situation and help to improve patient care through a happier and more productive workplace.

Allen M. Backman, MSc, PhD

Chapter
2
Introduction

Forward

The newspaper story began by asking, "How would you like to be a patient in an area hospital and be told you'll have to wait a couple of hours for whatever help you need because there are not enough nurses on duty?" The Dean of Nursing predicts that hospitals would soon be paralyzed by a lack of nurses. This story did not appear in a Saskatchewan newspaper, but in the Morning News of Northwest Arkansas on July 6, 2000.

A group of hospitals is investing $50,000 per year to encourage students to study nursing in return for a two year commitment to work for them after graduation. An official worries, "the average age of a nurse is mid-40s. We need some young blood. High school counsellors are no longer directing students into nursing, because there are so many more opportunities for careers now." This story appears in the local newspaper, the Cincinnati Post on July 3, 2000.

Unqualified staff are being used to assist in screening patients' blood and tissue samples because of chronic staff shortages in hospital laboratories. The shortage of qualified laboratory technicians is so severe that six out of 10 laboratories used unqualified technicians to keep up with workloads. This story appeared in the British newspaper the Telegraph on January 25, 2000.

The biggest health care problem facing the Government is solving the chronic nursing shortage, says the general Secretary of the Royal College of Nurses. More than 12,000 nurses leave the profession in England every year, while there are still 15,000 vacant posts. (The Times, April 4, 2000)

Staff shortages at Wakari Hospital in New Zealand have raised safety concerns and forced Healthcare Otago to cut beds from its already overcapacity forensic psychiatric ward. (Otago Daily Times, May 5, 2000) The New Zealand government recently budgeted NZ$1.8 million to the Health Workforce Advisory Committee over four years. (Otago Daily Times, June 16, 2000)

Clearly recruitment and retention of health care providers is an international issue.

Research Project — Workplace Opportunities Resources And Challenges For Saskatchewan

PURPOSE

Within the context of the many factors affecting supply and demand, to develop recommendations that will assist Saskatchewan Health and health employers understand the human resource challenges in the health workforce in the future, as well as provide examples of service delivery models that have the potential to help health employers more effectively deal with their recruitment and retention challenges.

- Allen Backman will conduct an examination in district health board workplaces to answer the following questions:
  - What are the current challenges in the recruitment of needed health providers and what challenges may present themselves in the near future? How can these be addressed?
  - What are the current challenges in the retention of needed health providers and what challenges may present themselves in the near future? How can these be addressed?
  - What are some examples of staff mix/service delivery models that currently exist in Saskatchewan and in other jurisdictions that have the potential to help health employers more effectively deal with their recruitment and retention challenges, both now and into the future.

  The Health Services Utilization and Research Commission (HSURC) will provide support to the research project as agreed to between the parties.

- The examination shall focus on health providers that provide hands-on patient care such as nursing, therapies and their aides/assistants. It shall exclude physicians but it may include other groups as deemed necessary by Allen Backman and HSURC.
- Allen Backman and HSURC shall jointly determine the methodologies to be followed in conducting the examination, which may include the following:
  - Solicit briefs and presentations from key stakeholders, including employers, the employers association, health professions, health unions, health educators, the public, and others.
  - Conduct stakeholder meetings, including CEOs and senior managers.
  - Conduct discussion groups with front-line health providers and managers.
  - Conduct independent research.
- In conducting the examination, the following shall be considered:
  - Demographic and other factors affecting supply and demand of health providers.
  - Whether work is organized in the most effective way possible.

- Whether practitioners' collective education, skills and abilities are being utilized to their full potential.
- Whether practitioners are unduly restricted in the amount or quality of care they can provide by administrative requirements or duties.

➢ A final report will be provided to the Deputy Minister on or before April 30, 2000.

Definitions

Health Provider, Practitioner: This report is concerned with those people who deliver diagnostic or treatment services, or who support those services within the context of a Health District, an affiliated agency or, as in the case of some ambulance services, under contract to a Health District.

HHRC: Health Human Resources Council

HSURC: Health Services Utilization and Research Commission

LPN: Licensed Practical Nurse

NEPS: Nursing Education Program of Saskatchewan

MSHP: Multiskilled health practitioner

Nurse: A Registered Nurse, Registered Psychiatric Nurse or Licensed Practical Nurse.

RN: Registered Nurse

RPN: Registered Psychiatric Nurse

SAHO: Saskatchewan Association of Healthcare Organizations

Values

Health WORCS will conduct research that:

❖ Is consistent with its mandate

❖ Is within its resources

❖ Is likely to have an effect on the health, satisfaction and efficiency of the workplace

❖ Is feasible

  ➢ Specifically, feasibility must include consideration of resources data availability / collectability, time constraints and cost

- Has potential to create or provoke change in the system
    - This change must have the probability of creating potential health benefits for users of the health care system
- Will create significant financial impact within the system

Useful research

Health WORCS strives to understand what policy makers want from research in order to do their jobs. Health WORCS undertakes to constantly ask itself how to produce research and analysis that will apply to policy makers and how best to communicate findings to stakeholders.

We will get it "right".

If Health WORCS's research and analysis is to be useful to policy makers, care must be taken to 'get it right'. A high premium will be placed on the quality of Health WORCS's findings. We will communicate only when we believe ourselves to be correct.

Integrity is Health WORCS's most important asset.

Integrity is Health WORCS's most important asset. We must be perceived to be honest by being honest. We must gain trust by being trustworthy. Stakeholders may not always like our findings, but they will be unable to accuse us of favouritism or deceit.

Chapter

3

Executive Summary

What We Learned

Purpose

Health WORCS was assigned the task of:

> Developing, within the context of the many factors affecting supply and demand, recommendations that will assist Saskatchewan Health and health employers understand the human resource challenges in the health workforce in the future, as well as provide examples of service delivery models that have the potential to help health employers more effectively deal with their recruitment and retention challenges.

We pursued several lines of research enquiry:

- We reviewed the health care literature relevant to the issues of job satisfaction, multi-skilling and skill mix, the health care labour market, recruitment and retention.
- We held focus style discussion groups with 238 front line health providers and front line managers from nine Districts and their affiliate agencies
- We consulted with regulators, unions and professional associations
- We held key informant interviews with senior management teams from 23 health districts and their affiliates.
- We solicited written submissions from system stakeholders

Front Line Provider and Supervisor Discussion Groups

Key challenges identified by the front-line health providers and supervisors we spoke to included:

- ☐ Problems created by current workloads and expectations placed on all professional staff to do work that was not 'theirs';
- ☐ Issues about the physical work environment such as access to equipment;
- ☐ People issues in the work environment including staff composition and organization, and opportunities for peer interaction;
- ☐ The inability to access permanent work to ensure a secure stable job in health in this province; and
- ☐ The lack of support in our health districts for professional development.

To address *recruitment challenges*, discussion group participants said individual health districts need a strategic recruitment plan that is a part of a provincial plan for recruitment for Saskatchewan. Specifically, discussion group participants told us, to attract new people to work in the health districts, health districts have to offer job security; address issues of pay equity; provide incentives such as moving expenses or signing bonuses; demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, including paid time off for, professional development; and sell potential employees (and their spouses) on the job and on the community.

To address issues of *retention and job satisfaction*, health districts need to show employees they are valued; they need to treat them with respect; and they need to treat them like professionals. They also need to build organizational commitment among their employees by involving front-line staff in planning and decision-making; by creating and supporting opportunities for professional development and growth; and by showing their appreciation to those on the front-line. Participants also told us that districts have to address job security concerns and attend to employees' workplace concerns about workload, work tasks, burnout, and the effect workplace issues are having on patients.

Regulators, Unions and Professional Associations

Most groups indicated that their members were not utilized to the full extent of their scopes of competencies and that full use of their skills could result in better patient outcomes and savings to the health care system. Many also expressed reservations regarding the use of providers whom they did not represent.

The organization of work and workload were major issues for many of these groups. Program management leads to managers having reports who do not necessarily share the same clinical or professional background. Management skills within the system are generally regarded as being poor. Front line management has been pared down too much and has left a void in the system. Providers are left without the necessary supports and resources or with too large a case load to be effective.

Many associations doubted whether the provincial government had a 'true vision' for the health care system and considered provincial policy and, especially health reform, as, at best, ineffective, and at worst, disruptive. Some expressed a desire that Saskatchewan Health would initiate a provincial recruitment and retention strategy while others saw these issues as having unique local characteristics requiring custom made local solutions.

Senior Management Teams

Senior managers need up-to-date baseline workload measurement tools and the resources to satisfy any shortfalls they might identify. There is no consensus as to how severe are the shortages of health providers, although rural districts are generally more hard hit than urban ones. Recruitment in many small rural areas is approaching calamitous proportions. Strategies that were once effective are less so and there is a reluctance, on the part of many providers to move to small towns.

Most managers recognize that inappropriate or inadequate use of all the competencies of various providers weakens the system's ability to respond to need. RNs and LPNs were especially seen as being under-utilized.

Most managers acknowledged that there is a great deal of competition within the system and with the private sector for human resources.

Many senior managers would like to create more permanent full time positions but feel hamstrung and dependent on casual employees. The situation is exacerbated by a policy of minimum staffing pervasive throughout the system. They also report that turnover within organizations is high as employees bid in and out of jobs.

Workload varies throughout the health care system. Some managers report very over-worked providers while others point to a great deal of slack within some workplaces. Many felt that workloads are not excessive, but certainly higher than in the past.

The recruitment and retention of managers has become problematic. Incentives are inadequate to entice clinicians to become front line managers and senior and middle management salaries cannot compete with other industries.

Managers expressed frustration with special care and home health aide programs and their inability to find resources for continuing education.

It was widely recognized that poor employee morale was common throughout the system and many blamed it on an 'underdog mentality' in which there is a false belief that working conditions and wages are poor in health care.

Summary of Recommendations

1.0 General and Broad-spectrum Recommendations

1.1 Saskatchewan Health must assist districts and their affiliates to develop strategies for attracting top talent including: augmenting student programs; providing a learning environment; using anticipatory hiring practices; and, involving employees in the hiring process.

1.2 Saskatchewan Health must assist districts and their affiliates to develop strategies for keeping employees including: holding managers accountable for retention; having a mechanism for identifying high-potential employees; having a clear understanding of the needs and values of employees; and having effective succession management systems.

1.3 Saskatchewan Health, Health Districts and their affiliates must develop senior nurses who can manage in a style consistent with magnet hospitals. This implies nurse managers who are visionary, enthusiastic, supportive, and knowledgeable; who maintain high standards and high staff expectations; who value education and professional development, who uphold positions of power and status within the hospital, are highly visible to staff nurses, are responsive and maintain open lines of communication and are actively involved in provincial and national professional organizations.

1.4 Organizational attributes common to magnet hospitals that need to be emulated in Saskatchewan are highly placed nurses within the management hierarchy, flat organizational structures with a few supervisory personnel, rather than a pyramid structure composed of many layers, decision making that is decentralized to the unit level, giving nurses on each unit as much discretion as possible for organising care and staffing in a manner most appropriate to the needs of their patients. Administrative structures must support the nurses' decisions about patient care and good nurse / physician communication must be fostered.

2.0 Communication

2.1 An internal marketing mechanism must be established to continually assess the needs of people who work within the health care system and to articulate and disseminate a vision for the direction of the system that can be embraced by those charged with delivering programs and services

2.2 No substantive systemic reform should be undertaken in Saskatchewan without a clearly thought out, well defined and agreed upon labour readjustment strategy. This strategy must be agreed upon by Saskatchewan Health, the Districts and the Unions and it must be publicly articulated to minimize angst.

2.3 A national campaign to increase the public's awareness of health care provider careers should be undertaken. This recruitment campaign must be national in scope, sustainable over the long run and directed at men and women who are at the age of post secondary education choice.

3.0 Education and Training

3.1 Courses for special care and home care aides should be offered jointly by SIAST, aboriginal educational institutions, or other educational institutions with health districts or SAHO as full partners. Tuition rates should be uniform and affordable regardless of the geographic location in which the course is offered.

3.2 Ongoing collaboration between the Department of Health, SAHO, employers and the universities is essential in order to develop management training programs for front line managers.

3.3 The present number of seats in the NEPS and the SIAST Practical Nursing Program should be increased as the resources of SIAST and the University of Saskatchewan permit. Funding should be allocated to facilitate this expansion. Saskatchewan should encourage other provinces to likewise increase their seats.

3.4 Saskatchewan Health has recently moved to encourage former RNs, RPNs and LPNs who have left the profession to re-certify by contributing towards their tuition costs. This is a laudable approach and the Department should continue to pursue this and similar strategies.

3.5 As part of the funding for health districts, Saskatchewan Health should allocate, according to its population/needs formula, specific funding for continuing education of licensed and self regulated providers who are employed directly by health districts. Similar funding should be made available to address the continuing education needs of unlicensed providers such as aides and technicians. This funding should include sufficient money is available to attend, and paid time off for, professional development.

3.6 The Provincial Health Human Resources Council[1] (HHRC) will assess the number of educational seats available in all health disciplines relative to system need and develop strategies to ensure appropriate clinical placement opportunities for students at both the undergraduate and post graduate levels. The HHRC will also assess the uses and need for advanced practice nurses and develop strategies for their education and/or recruitment. Over time, this role of the HHRC will be expanded to include other provider categories as needed, such as physical therapists and midwives.

4.0 Interprovincial, Regulatory, and Licensing Issues

4.1 Saskatchewan Health must enlist the support of the federal, provincial and territorial governments to establish a Health Human Resources Council (HHRC) to identify strategies and methods of supporting better human resource planning with emphasis on recruitment, retention and appropriate utilization of skills.

4.2 An analogous HHRC body must be established at the provincial level to do similar work in Saskatchewan. While the Department should retain control of the agenda, membership should include representatives of SAHO, unions, regulators and the Universities and SIAST. HHRC should concentrate on (but not be limited to) strategies pertaining to workplace plans that contribute to job satisfaction, effectiveness, the full utilization of skill mix, increasing the proportion of permanent full time and permanent part time positions and ensuring adequate supply of providers from educational institutions.

4.3 Saskatchewan should work with the SRNA, RPNAS and other provinces to ensure that international nurses can take the Canadian licensing examinations overseas. Alternatively, an accommodation, similar to the Medical Professions Act's Provisional Licensure[2] may allow international nurses to come to Saskatchewan and have five years, or another period deemed appropriate by the SRNA or RPNAS, to successfully write the Canadian exams.

4.4 All licensed providers should be assigned a permanent identifier upon first licensure in Canada, which will follow them from province to province throughout their professional lifetimes. While mobility information should be available to regulators and researchers, appropriate privacy of information rules should be developed parallel to this system

5.0 Supports and Incentives

5.1 Systems to facilitate an ongoing understanding of the needs and values of employees is an essential part of retaining them. It is the employer's obligation to understand these needs and values, but these are both local and universal in nature. SAHO (at the provincial level) and Health Districts and their affiliates (at the District level) should establish ongoing working groups, to explore, research, analyze and make recommendations. While membership of these groups might contain managers and union representatives, at least one half of the membership should consist of front-line providers with no management or union responsibilities.

5.2 Retention strategies must be tailored to the life-cycle stage of employees.

5.3 To address *recruitment challenges*, Health districts have to offer job security; address issues of pay equity; provide incentives such as moving expenses or signing bonuses; demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, and paid time off for, professional development; and sell potential employees (and their spouses) on the job and on the community.

---

[1] See Recommendation 4.1

[2] See Sections 29(1) and 29(2) and bylaw 21(4)

5.4 To address issues of *retention and job satisfaction*, health districts need to show employees they are valued; they need to treat them with respect; and they need to treat them like professionals. They also need to build organizational commitment among their employees by involving front-line staff in planning and decision-making; by creating and supporting opportunities for professional development and growth; and by showing their appreciation to those on the front-line.

5.5 It is recommended that a formalized system of peer support be established for occupational therapists, physical therapists, and community health nurses. This network should include regular case conference consultation with teams of providers as well as regular continuing education conferences.

5.6 Incentives to become front line managers must be improved so more providers will aspire to management positions.

5.7 Work should be organized to equip providers with the necessary supports to do their jobs. This includes such things as adequate office and filing space, ward clerks, porters, receptionists and physical equipment and supplies. As much as possible, tasks relating to clerical or maintenance work, the co-ordination of non clinical activities or paper work not directly related to clinical obligations or expertise should be done by someone else.

6.0 Skill Mix and the Structure of the Workplace

6.1 Shortages of providers or problems with distribution to rural areas will be an ongoing problem with unpredictable seriousness. A range of responses will become necessary depending on how critical the situation becomes. The amount of responsibility given to providers must depend on several factors. Where shortages of the most qualified providers occur, there are two choices.

a) Cease to provide a given service locally and move that service to a larger community, or

b) Provide a different level or mix of services by different providers to the same or a different group of clients.

Decision making will depend on how acute provider shortages become and on what degree of risk a community is willing to accept. Communities must have all the necessary information available if they are to understand, participate in and embrace decisions.

6.2 Licensed Practical Nurses are under-utilized in Saskatchewan. The best use of these independent providers is as members of a care team working with RNs or RPNs and other providers in a way that will maximize appropriate skill mix. There is no question that the appropriate use of LPNs is safe. As a principle, Licensed Practical Nurses ought to be utilized to the fullest extent of their competencies in the context of a health care team. Efforts must be undertaken to upgrade all practising LPNs to the same level, including medication and catheterization certification.

6.3 Registered Nurses and Registered Psychiatric Nurses are under-utilized in Saskatchewan. In fulfilling their role as providers of patient care, they must exercise leadership within a care team, working with other providers in a way that will maximize appropriate skill mix or as providers of primary care in community settings. Emphasis on leadership functions and the full employment of their scope of practice and competencies is essential. Organizational supports, which will allow them time away from direct patient care duties, to facilitate their full participation within the care team, such as conferencing with other team members is part of their role.

6.4 Many health providers are under-utilized. Saskatchewan Health, Health Districts and their affiliates need to constantly explore and exploit opportunities to use providers in the most appropriate ways and to fully integrate all providers into the team. While not advocating recklessness, Health WORCS also discourages turf protection.

6.5 Two new categories of workers should be established: Weekend Worker and Night Worker for all three classes of nurses as well as special care aides. Terms should be negotiated to provide special monetary incentives to work weekends an/or nights exclusively. For example, the Ontario Nurses Association collective agreement establishes a new category of weekend worker. These nurses work an average of 30 hours per week and are paid 37.5 hours

6.6a Full time positions need to be created and offered to new grads and out of province applicants. Seniority of providers from other provinces needs to be transferable, even if the courtesy is not reciprocated. More flexibility must be built into the system so that people may opt for full time or part time work according to their needs.

6.6b If employers are to wean themselves from dependence on casual labour, they and the unions must negotiate more flexibility in terms of their ability to select appropriate candidates for vacant and new positions.

6.7 SAHO must enhance training for all levels of managers so that collective agreements are understood and managers are able to effectively manage within them. This should include, but not be limited to, understanding progressive discipline and creative problem solving.

6.8 Unions and SAHO must engage in frank and open discussion as to whether collective agreements present recruitment and / or retention barriers. They must work together to create collective agreements which enhance the ability of the health care system to have adequate human resources. This discussion might include such strategies as interest based bargaining.

6.9 Unions, Districts and their affiliates need to continue to pursue creative solutions within the framework of collective agreements to better satisfy client needs.

7.0 Further Research Needed

7.1 The philosophy of minimal staffing[3] needs to be re-examined. Research to establish the effects on job satisfaction, retention, recruitment and client/patient outcomes of minimal staffing must be undertaken.

7.2 It is recommended that a provincial clearinghouse for research on Health Human Resource strategies be established to track and co-ordinate research activities. Saskatchewan Health should work with its provincial, federal and territorial counterparts to create a similar mechanism for identifying, sharing and disseminating health human resources research nationally.

---

[3] The report discusses the tendency to use the absolute minimum number of providers in the interests of economic efficiency.

7.3 There have been several meetings between the Department of Health, SUN and several health districts regarding a pilot project in which providers and management would be given a great deal of latitude in designing work. Such endeavours are to be strongly encouraged in an effort to identify innovative solutions to human resource issues.

7.4 It is recommended that a provincial research project be established to develop workload measurement tools appropriate to the Saskatchewan context, beginning with tools for institutional acute and long term nursing care. Such a research project should be lead by experienced researchers and should work closely with health districts and affiliates, unions and regulators.

8.0 Northern Issues

8.1 As part of the construction of the new hospital in Laloche, additional housing dedicated to staff be constructed.

Chapter 4

Methodology

Overview

This document is a summary of research conducted by Dr. Allen M. Backman and the Health Services Utilization and Research Commission (HSURC) about workplace recruitment, retention, and job satisfaction issues in Saskatchewan. The research was composed of several elements which, together, form a broad review of these issues.

Specific components included:

- A review of the literature on recruitment and retention
- Discussion groups with front-line health providers and supervisors (conducted by HSURC)
- An analysis of written submissions on these issues solicited from interested parties (analyzed by HSURC).
- Interviews with Senior management teams and representatives of regulatory agencies, professional organisations, and unions.

This review provided us with the opportunity to develop an understanding of recruitment, retention, job satisfaction and skill utilization issues within our own jurisdiction, i.e., within Saskatchewan. As well, gathering information from front-line workers, health district managers, regulatory, professional, and union groups gave us several perspectives on the issues in this province.

The primary objectives of this research were to:

1. Identify current and future challenges in the recruitment of needed health providers;
2. Identify current and future challenges in the retention of needed health providers;
3. Identify staff mix/service delivery models
4. Identify how recruitment and retention challenges may be addressed

Discussion Group Design[4]

Background

We collected Saskatchewan data on recruitment, retention, and job satisfaction because of a lack of local information on the issues. In this exploratory and qualitative research we did not address specific hypotheses. We wanted to see which issues were consistent across districts or workplaces and consistent with research from other jurisdictions. We also wanted to identify issues unique to Saskatchewan, or to particular districts or workplaces.

---

[4] This section was contributed by HSURC and was prepared by Joanne Hader, Senior Research Officer.

In addition to HSURC's work collecting information in discussion groups with front-line health workers and supervisors, Dr. Allen Backman conducted semi-structured interviews with senior managers from the health districts, and with representatives of regulatory agencies, professional associations, and unions. We talked to many different people to obtain a number of perspectives on the issues. Dr. Allen Backman oversaw the review. He contracted with HSURC to conduct the discussion groups with front-line health providers and supervisors.

Discussion Groups

A discussion or focus group is one of several qualitative data collection methods. These methods emphasise experiences, meanings, and views of the participants. They allow the researcher to explore both in depth and in detail, people's knowledge, attitudes, beliefs, feelings, and perceptions. The goal of qualitative research is to answer questions such as "what are the x's, how do they vary in different circumstances, and why?" rather than "how many x's are there?"

These discussion groups **use group interaction to generate data**. They are particularly effective in gathering information about personal issues or sensitive topics. Participants are encouraged to talk to each other, exchange anecdotes, and comment on the experiences and points of view of others in the group. The admission by other group members that they too have particular problems or engage in particular behaviours legitimizes discussion and provides a level of openness and candour not found in other research circumstances. The group therefore, through a shared sense of experience, can enhance the breadth and depth of discussion and the data collected. The participants often feed off each other's experiences, and they feel more comfortable sharing because they are not being isolated for in-depth scrutiny (as they might be in an individual interview).

Other terms used for these discussion groups are: focused discussion group and focus group interview. The term *focus* simply means that the discussion is limited to a small number of issues. Methodological references are provided at the end of this document.

Research Questions

In the discussion groups with front-line health providers we wanted to gather information from participants on:

- ☐ Recruitment issues – what attracts people to this type of work;
- ☐ Retention issues – what keeps people doing this kind of work;
- ☐ Employee satisfaction – what about the work makes people happy or not happy;
- ☐ How can we meet challenges identified above – what can be done to recruit people to the health field in this province, to keep people from leaving the professions, and to ensure people are happy in their work.

Discussion Group Methodology

Throughout February and March 2000 we convened 25 discussion groups in nine health districts in southern Saskatchewan, involving a total of 238 participants. We targeted front-line health providers and supervisors. Our sampling procedure was non-random, or purposeful, based on a method commonly known in market research as quota sampling. In deciding the appropriate sampling strategy to employ, we weighed the importance and practicality of generating representative information against the value of generating in-depth information. We felt it was important to do a bit of both.

Districts Selection Process

We sampled districts to study in depth, and tried to ensure they were geographically dispersed throughout the province. We conducted urban and rural groups, groups in districts with large facilities (e.g., base hospitals) and groups in districts that are very small, rural, and in which the health workforce is quite dispersed.[5] The districts included in the sample are in Appendix A.

In all participating districts, local contacts made the arrangements for the groups. These individuals were health district employees. They identified and contacted participants, booked meeting rooms, and arranged for refreshments for the sessions.

Participant Selection Process

We asked our local contacts in the districts to 'randomly' select the discussion group participants from employee or seniority lists whenever possible. Our goal with this sampling method was to ensure that people who had issues (or alternatively who may not speak up) were not hand picked to come to the discussion group. We asked for participants who were providing hands-on patient care. We asked them to set up groups of 8 – 12 participants representing different sectors (acute care, community care, long term care) and with varying degrees of experience (i.e., we wanted people with seniority as well as people fairly new to their jobs).

We used the 1998 Saskatchewan Health Employer Survey Report to get an idea of the distribution of the health workforce in Saskatchewan. In most districts we conducted groups with:

- A mix of professionals including all three types of nurses (Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses); the therapies (physiotherapy, occupational, speech); medical social work; psychology; etc.
- Health care aides including home care aides, special care aides, nurses aides and;
- Front-line supervisors.

In some districts we convened groups of:

- Nurses (and no other health professionals);
- A mix of professionals from just the institutional sector or the community;
- A mix of professionals from just acute care or non-acute care;
- Just technicians (lab technicians, microbiology, virology, and chemistry departments.; x-ray technicians);
- Highly specialized and difficult to recruit health professionals (of which there are few required in the system) such as sonographers, profusionists, nuclear medicine and MRI technicians.

Information on participants' occupational groups and their years of experience and the participant consent form are provided in Appendix B and C.

Discussion Group Format

Three experienced facilitators led the discussion groups. A trained co-facilitator was also present at each group. We based the group discussions on the *technology of participation* focused conversation method developed by the Institute for Cultural Affairs. Using this method one leads a discussion through the four steps of the critical thinking process: objective, reflective, interpretative and decisional levels--or the facts, the feelings, the meaning, and required actions.

---

[5] We had planned a number of groups in the north, but were unable to complete them due to schedulilung diffuculties. We did make on site visit to the community of Laloche where we interviewed several managers and RNs.

On average, the group sessions lasted three hours with a break about half way through. We conducted the groups in teams to reduce inter-rater variation (i.e., the facilitators had the opportunity to observe each other). We also tried to mitigate any factors that could negatively influence group dynamics and the value of the data collection process. We did this by setting up relatively heterogeneous groups; by ensuring meeting rooms were comfortable and refreshments were available; and by letting participants know that contributing to any one part of the discussion was the participants' choice. We encouraged discussion ***only as far as the participants were comfortable***. It was the facilitators' role to create a safe environment for discussion. Similarly, it was the participants' choice to contribute to the discussion of a particular topic. We respected that choice, particularly if a topic created distress due to personal experience.

We conducted a pilot test with a mixed professional group and made significant modifications to the data gathering process as a result. For example, most experts recommend discussion groups should be 60-90 minutes in length. Using this benchmark, we underestimated the time we would require for these groups—people had a lot to say. Because we now had groups of three hours in length, we also modified the group process to give participants an opportunity to interact in a variety of ways (i.e., in large group discussion around the table, and in smaller groups). The facilitation guide is provided in Appendix D.

For most of the groups we conducted, we *did not need* to use the questions and probes available to us in the facilitation guide to generate discussion. That is, once the topic was introduced to the group as a discussion of workplace recruitment, retention and satisfaction they more often than not needed little prompting to tell us their issues, to ask each other questions, and to probe others' responses. Many groups also moved the discussion on to ways of addressing challenges identified, again without our prompting.

Analysis[6]

Upon completion of each discussion group, the co-facilitator summarized the information from notes taken, and flip-chart sheets used, during the sessions. These 25 summaries formed the basis of subsequent reporting. We shared this information among facilitators for debriefing on group process issues and for assessing the findings on an on-going basis. We conducted a preliminary analysis following completion of about two-thirds of the groups. We tape-recorded all of the discussion groups (audio). We felt the taping was crucial as it allowed us to capture quotes in the participants' own words. We also wanted the tapes available to review any findings that were unclear and to validate our summaries as required.

Steps in the Data Analysis

1. Qualitative data analysis is an iterative process of reviewing, digesting, and summarizing data. We conducted this analysis in a series of steps beginning with one

---

[6] This section was contributed by HSURC and was prepared by Joanne Hader, Senior Research Officer.

researcher reading through the summaries to become familiar with all the data. At this point we kept the information from each category of group separate. This first step allowed us the opportunity to ascertain the quantity and quality of the data from the different groups and to assess the factors influencing its variance. For example the *information generated from all of the groups was not equally comprehensive.* Upon reviewing the groups in which only a few issues were raised, we found some had particularly vocal participants that dominated and steered the agenda. As a result all voices or perspectives may not have been heard in some groups and this is a risk for this sort of methodology.

2. In the second step, data organization and reduction, we created categories of data for subsequent analysis. In our preliminary analysis we had found that participants identified challenges to recruitment or retention around "how the work is organized", "how the workplace is managed", and "how the external environment affects the workplace". We took the data from each discussion group and sorted it into these categories and into sub-categories within them. This process was also iterative in that data that did not clearly fit into a category was used to modify the categorizing system. To retain the integrity of the data, and not impose our own biases on it (for example, by using researcher jargon), we did not paraphrase the information, and we retained reference to quotes on the tapes (we had tried to use the participants' own words in our summaries, as well). The final table of categories is provided in Appendix F.

3. We used the same process to analyze the solutions to recruitment and retention challenges. The 'solutions' the groups generated were in response to the question: *It is your job to recruit and retain the front-line staff in your district. Knowing all the issues we have discussed today, what would you do?* These are provided in Appendix G.

4. The final step is data verification. To validate the data reduction process, the discussion group facilitators and co-facilitators reviewed the categorizing system. Further validation occurred when these discussion group findings were triangulated with the information from the published literature, from written submissions and from Dr. Backman's interviews.

Key Informant Interviews

One of the avenues to investigation undertaken by Health WORCS was a series of group semi-structured key informant interviews with senior management teams, unions and regulators. These interviews were usually conducted with small numbers of subjects and so, in some ways, resembled focus groups more than one-on-one interviews (Dillon et al 1993, p.141). Tull and Hawkins (1990, p.401) refer to this technique as mini-groups. A small number of interviews were conducted one-on-one. The focused interviews were designed to allow the researcher to explore both in depth and in detail, management's, unions' and regulators' knowledge, attitudes, beliefs, feelings, and perceptions.

These discussion groups use group interaction to generate data. It was decided that this research method was suited to our purpose for several reasons: 1. The value of interaction lies in allowing participants the chance to generate new thought. Small groups of senior managers and union leaders would be able to talk to each other, exchange anecdotes, and comment on the experiences and points of view of others in the group, 2. The subject matter is not so sensitive that participants would withhold information or moderate their remarks, and 3. It is relatively easy to get members of a union executive, a senior management team or a regulator together in one place at the same time. Since the groups were generally much smaller than is standard for focus groups, we retained the advantage offered by one-on-one interviews of allowing a greater depth of response per individual. This is well suited to complex subject matter where the participants are very knowledgeable. (Dillon et al 1993, p.141)

Since this research was both exploratory and qualitative, we did not attempt to address specific hypotheses. Our goal was to see what issues were consistent across districts or workplaces and consistent with research from other jurisdictions. We also wanted to identify issues unique to Saskatchewan, or to particular districts or workplaces.

In the Interviews we wanted to gather information from participants on:

- What are the current challenges in the recruitment of needed health providers and what challenges may present themselves in the near future? How can these be addressed?
- What are the current challenges in the retention of needed health providers and what challenges may present themselves in the near future? How can these be addressed?
- What are some examples of staff mix/service delivery models currently existing in Saskatchewan and in other jurisdictions that have the potential to help health employers more effectively deal with their recruitment and retention challenges, both now and into the future?

Sampling

We approached all the major health care unions, health districts and a selected group of regulators and professional associations. All agreed to participate in some form. One union, SGEU participated by providing information by telephone.

Interviews were conducted with representatives of the
- Canadian Union of Public Employees,
- Service Employees International Union,
- Saskatchewan Union of Nurses,
- Health Sciences Association,
- Saskatchewan College of Physical Therapists,
- Saskatchewan Registered Nurses Association,
- Saskatchewan Association of Licensed Practical Nurses,
- Registered Psychiatric Nurses Association of Saskatchewan,
- Saskatchewan Psychological Association,
- Saskatchewan Medical Association, and the
- Saskatchewan Association of Healthcare Organisations

Senior managers from 23 districts were interviewed by Dr. Allen Backman.

Participating Districts were:

Battlefords
Gabriel Springs
Greenhead
Keewatin Yathe
Lloydminster
Midwest
Moose Jaw Thunder Creek
Moose Mountain
North Central
North Valley
Northwest
Pasquia
Pipestone
Prairie West
Prince Albert
Regina
Saskatoon
South Central
South Country
Southeast
Swift Current
Touchwood Qu'appelle
Twin Rivers

In all cases it was suggested that we would like to meet with a number of representatives with three being the ideal. Interview group sizes actually varied from 1 to 14 with a mode of 3. Interviews were conducted in various locations around Saskatchewan and we attempted to provide interview opportunities that would minimize travel for subjects.

Analysis

Upon completion of each key informant interview, Dr. Backman wrote his field notes, including the information he had written during the interviews. These documents formed the basis of subsequent reporting.

Steps in the Data Analysis

1. Qualitative data analysis is an iterative process of reviewing, digesting, and summarizing data. We conducted this analysis in a series of steps beginning with the review of each field note. At this point we kept the information from the different interview groups separate. This first step allowed us the opportunity to ascertain the quantity and quality of the data from the different groups and to assess the factors influencing its variance.

It became apparent immediately that information from the management groups was consistent but that there were some differences that could be explained by whether the team had come from a rural, urban or large urban district. We did not notice this inconsistency with union and regulator teams and these latter groups more often provided us with information that had less variance within and between groups.

2. In the second step, data organization and reduction, we investigated whether the information collected in the key informant interviews were consistent with the themes identified in the discussion group data analyzed by HSURC. These were: "how the work is organized", "how the workplace is managed", and "how the external environment affects the workplace". Although there were some consistencies, not all themes emerging were amenable to classification in the same way. This incongruence is explained by two things. First, the information we sought from the front line provider and manager groups was somewhat different from that sought from the stakeholder discussion groups. For example, we explicitly asked the management groups, unions and regulators about staff mix/service delivery models. Second, we ought not to expect the perceptions of front line providers to be congruent with those of management, unions and regulators.

The themes deriving from the Management interviews were:

1. Workload Measurements
2. Staffing
3. Workload
4. Retention and Recruitment Issues
5. Staff Mix and Skill Mix Issues
6. Collective Agreements and Management Rights
7. Attitudes towards the Health Care System Environment

The themes deriving from the Union and Regulator group interviews were:

1. Skill Mix and Distribution of Work
2. Organization of Work
3. Attitudes towards Government
4. Attitudes towards Health Reform
5. Workload Issues
6. Casualization of the Workforce
7. Recruitment and Retention Strategies
8. Other Issues

We took the data from each interview and sorted it into these categories and into subcategories within them. This process was also iterative in that data that did not clearly fit into a category was used to modify the categorizing system.

3. The final step is data verification. To validate the data reduction process, Dr. Backman revisited the categorizing system. Further validation occurred when these discussion group findings were triangulated with the information from the published literature, from written submissions and from HSURC's analysis.

Chapter

5

What We Read

Literature Review

How Do You Create Job Satisfaction?

In order that people may be happy in their work, these three things are needed: They must be for it. They must not do too much of it. And they must have a sense of success in it.
John Ruskin (1819-1900)
English art critic and historian

Simply defined, "job satisfaction is the balance between work stressors and work rewards" (Corey-Lisle, Tarzian, Cohen and Trinkoff, 1999, p. 36). Locke (cited in Tovey & Adams, 1999) has described job satisfaction as:

> "… a pleasurable or positive emotional state resulting from the appraisal of one's job or job experience. Job satisfaction results from the perception that one's job fulfils or allows the fulfilment of one's own important job values, providing and to a degree that those values are congruent with one's needs."

Tovey and Adams (1999) then, suggest that job satisfaction is in essence a personal experience, and that it is possible for sources of satisfaction or dissatisfaction to vary among those within professional groups. This may be one reason why the literature reports no clear consensus as to what factors create job satisfaction. However, that being said, variations of general sources of job satisfaction are not likely to be too significant.

Most behavior is multi-motivated.
- Abraham H. Maslow (1954, 102)

According to the work of Maslow (1954) there is a five-level hierarchy of human needs, where the lowest is basic physiological needs and the highest need is self-actualization. Tovey and Adams (1999) share that a known factor in nurses' low level of job satisfaction is their "unmet need for personal development and career advancement" (p.153), Maslow's fifth level need.

Organizations have been remiss in this regard, as the lack of investment in staff in this area is consistently linked with low levels of job satisfaction (Tovey and Adams, 1999), and nurses' job satisfaction is vital to their retention (Kangas et al., 1999). Further to this, specialization has been shown in studies to be a major contributor to the job satisfaction of nurses (Kangas et al., 1999). It also appears that nurses who feel they have access to promotional opportunities are more satisfied than others (Tovey and Adams, 1999). In Barrett and Myrick (1998), Burton and Burton (1982) confirm that nurses' job satisfaction comes from self-fulfilment and a feeling of achievement or accomplishment.

A second job satisfaction theory is the two-factor motivating theory by Herzberg et al. (1959; Herzberg 1966). Satisfaction or dissatisfaction in this theory is based on two separate variables. The intrinsic factors or 'motivators' they established to be job 'satisfiers'. These are such things as achievement, recognition, responsibility, and work itself. Extrinsic factors or 'hygiene' factors they established to be job 'dissatisfiers'. These are company policy, administration, supervision, salary, interpersonal relations and working conditions. Much of the nursing research on job satisfaction is focused on these 'hygiene' factors (Tovey and Adams, 1999). Perhaps more attention should be paid to intrinsic factors by those looking for solutions for job satisfaction, as these are areas noted in much of the recent literature as being highly associated with job satisfaction.

It was reported that the strongest negative relationship to job satisfaction was found to be stress, and the strongest positive relationship was organizational commitment. Job satisfaction also had significant positive relationships in communication with supervisors, autonomy, recognition, and communication with peers. A further highly rated factor for low job satisfaction was excessive workload (Corey-Lisle et al., 1999). In other words, "job satisfaction is influenced positively by the challenging aspects of work duties, autonomy, supportive supervisory staff, feeling appreciated, and work group cohesiveness" (Corey-Lisle et al., 1999, p. 36).

> **Nothing creates more self-respect among employees than being included in the process of making decisions.**
>
> **-Judith Bardwick, University of California at San Diego, The Plateauing Trap, AMACOM, 1986)**

Corey-Lisle et al. (1999) speak of research that found greater job satisfaction results from a supportive organizational environment (Kangas, Kee and McKee-Waddle, 1999). Further, they contend that there will be a positive influence on job satisfaction where nurses regard change as an opportunity to grow, to have increased autonomy and intellectual stimulation, and for group cohesion.

According to Laschinger and Sabiston (2000), the ability for nurses to practice their profession according to the professional standards and values is a key determinant to their satisfaction and commitment to the profession and organization. Workplace empowerment approaches such as participative management and shared governance are innovations in the right direction to creating job satisfaction in this area, for this, the largest group of health care providers.

The improvement of job satisfaction addresses retention and recruitment issues, but there has been evidence for some time that it also addresses patient satisfaction and outcomes (see, for example, Weisman and Nathanson 1985).

Conclusions

Several factors mentioned above determine whether or not health care workers are satisfied in their jobs. Yet the single greatest determinant that seems to prevail is autonomy. Greater autonomy increases job satisfaction, which in turn decreases turnover or the desire to leave. Hanson, Jenkins and Ryan (1990) found in their study that the strongest relationship was between job satisfaction and nursing autonomy.
They cite Wilson (1987), who remarks that "nurses are educated to become independent-thinking professionals, accountable for their practices." Often times however, the work setting does not allow for this development of autonomy, and it might be in the best interests of health care to more closely consider this development.

Multiskilling (Cross-Training) and Skill Mix

The literature is replete with papers on multiskilling and skill mix, but the topics are fraught with controversy. As both human and financial resources in health care are quickly waning, both these strategies have been suggested to counteract the problem of constrained financial and human resources.

"Skill mix is the balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area … the optimum skill mix is consistent with the efficient deployment of trained, qualified and supervisory personnel and the maximization of contributions from all staff" (Needham, 1996).

Throughout the literature consensus is found on only one aspect of multiskilling, that is, that no one is able to clearly define just exactly what multiskilling means in terms of health care practitioners. The National Multiskilled Health Practitioner Clearinghouse at the University of Alabama at Birmingham gives this definition on multiskilling:

> "The multiskilled worker is a person who is cross-trained to provide more than one main function, often in more than one discipline. These combined functions can be found in a broad spectrum of health related jobs ranging in complexity from the non-professional to the professional level, including clinical and management functions. The additional functions (skills) added to the original health care worker's job may be of a higher, lower or parallel level"

Even with such a definition, still no conclusions have been made as to what a multiskilled health practitioners' (MSHP's) responsibilities are, or just what skills and abilities one such practitioner is required to possess (Pietranton, 1995).

In a simpler form, a multiskilled employee is someone who performs interdisciplinary tasks or functions (Cameron, 1995). However, as far as nursing supporters are concerned, it is not possible to break nursing down into tasks or functions without taking away from the core essence of nursing ideology, which is to provide comprehensive patient care through interaction with the patient on different levels, during various care giving tasks. This is an ideology that begins the very first day of nursing education. That education develops "an active knowledge and awareness embodied in the performance of the nursing intervention, which requires active assessment and discretionary judgement, and relies on interpretation of the situation, moral agency, patient advocacy, and more" (Cameron, 1995, p. 7).

The Case for Multiskilling and Skill Mix

The concept of multiskilling or cross-training is not a new idea. Today however, the greatest push for multiskilling workers comes from the escalating need to make health care more efficient and cost effective, while maintaining the highest quality of patient care possible. Multiskilling may plausibly reduce lengths of stay by diminishing the gaps in the continuum of care, thereby enhancing the quality of care (Foto, 1996). These gaps could be any number of things, including waiting times between appointments with different practitioners or treatments, travelling time between departments, and the wasted time patients experience while having to be passed among caregivers of various capabilities.

A 1991 survey by Vaughan, Fottler and Bamberg reported that 25 per cent of the hospitals they surveyed were using MSHP's. They established the principal reasons for the use of MSHP's to be flexibility and efficiency in staffing. They further found that cost effectiveness due to the reduction of employees was important. (Collins, 1997).

Those who support multiskilling argue that it provides professionals with an opportunity for occupational growth, which leads to increased job satisfaction and decreased burnout and turnover (Collins, 1997). Supporters also argue that it gives workers an opportunity for job enrichment, increased employability and job security, and improves communication (CAMRT, 1995).

There is support for the use of unlicensed assistive personnel (UAPs) as a necessary component of providing quality care even by nursing associations. In its published 1993 *Position Statement on Registered Nurse Utilization of Unlicensed Assistive Personnel*, the American Nurses Association stated that "qualified, competent, trained, and supervised unlicensed personnel are essential in providing direct and indirect patient care under the direction of the registered nurse" (Holzemer, 1996, p. 24).

The literature regarding skill mix discusses the issues surrounding the use of UAPs. The greatest uncertainty toward the use of UAPs tends to come from health providers rather than managers. Managers see the decision to use UAPs or other support personnel as an answer to their cost reduction and labour shortage dilemmas (Russell and Kanny, 1998; Ramsay, 1995). Nurses fear such use because they feel their jobs and patient safety are both in jeopardy. They fear losing their jobs to unlicensed, unqualified personnel, and that these same people would become responsible for patient care.

However, proponents argue that this fear is unfounded since health care cannot and will not be provided without the level of skill which only nurses can provide. What is happening, and will continue to occur, is that health care will no longer be provided at a 100 per cent RN staffing level.[7] Even if an all RN staffing level of care were necessary, it is becoming increasingly difficult to recruit qualified skilled nurses, as there is a shortage in the labour market. Instead, some combination of RN/LPN and UAP skill mix is the most cost-efficient and accountable practice for health care delivery today.

Advocates assert that when appropriately and thoroughly trained, UAPs become an asset to hospitals for a couple of reasons. First, they allow hospitals to function more cost-effectively through the use of lesser paid staff performing non-nurse-required tasks such as changing beds, bathing patients and drawing blood. Second, it provides nurses with "a golden opportunity … to begin to practice in a more professional setting and practice in a more professional way and do the things that only they can do, that they would love to do if they had more time" (American Health Consultants, 1995, p. 76).

Operating within therapies, there are, generally speaking, two levels of support personnel. Therapy aides are trained 'on the job', whereas therapy assistants have some degree of formal education and training. The use of physical therapist assistants (PTAs) enhances client care by improving the frequency and availability of the routine services offered to clients (Task Force on Support Personnel, 1996), while freeing in this case physical therapists to evaluate, interpret and make judgements about patient activities, develop treatment plans (Lupi-Williams, 1983), provide specialized procedure and conduct clinical research (James, 1983). This becomes especially true in rural settings where recruitment of therapists, like the speech-language pathologist, is much more difficult (Kimbarow, 1997). PTAs comprise approximately 20 per cent of all staff in physical therapy practice (Ellis, Connell, and Ellis-Hill, 1998), and James (1983) asserts that the use of PTAs leads to a higher quality of client care.

Organizations that have been successful in implementing the use of UAP suggest the key for its success include understanding exactly what you need UAPs for and what tasks they are legally allowed to perform. Then it is imperative to have a clear job description so that all tasks are delineated and all staff, including the UAPs, understand exactly what the UAP can and cannot do. They even suggest dressing UAPs differently for a clear distinction between staff to everyone, including patients.

---

[7] To a certain extent this situation does not apply to Saskatchewan anyway. Most Saskatchewan UAPs are Home Care and Special Care aides with some nurses/service aides in acute care. Saskatchewan has never functioned with 100% RN staffing levels. In addition, most Saskatchewan UAPs (including many technical providers and physical and occupational therapy aides) have formalized and standardized training programs offered through SIAST and other community colleges. In addition, LPNs are not UAPs, but members of a self-regulating profession.

The Case against Multiskilling and Skill Mix

Collins (1997) raised some concerns regarding multiskilling pertaining to the maintenance of multiple skill competencies, scheduling and co-ordinating among departments, replacing MSHP's who leave, as well as managing liability issues (Collins, 1997).

Some of the hesitation or reservations toward multiskilling come because it challenges traditional thinking on specialization and scopes of practice among practitioners. Too, it creates fear over the deterioration of professional roles, practice standards and professional autonomy. As well, it raises concerns for the safety of patients, and the ethics in specialized task delegation by professionals to unqualified non-professionals (CAMRT, 1995).

To non-nurses, activities such as giving someone a bath, emptying a catheter bag or the dressing of a wound may seem to be fairly simplistic tasks or procedures, but to a nurse these activities are more encompassing. For instance, the interaction between a nurse and a patient during a bath can be vital to patient care. It gives the nurse an opportunity to assess such things as skin health, the patient's self-care ability or may even provide an opportunity for teaching a patient about his or her condition (Cameron, 1995).

Again, one may be inclined to think that emptying a catheter bag is a simple task with not much thought beyond the action itself, but to a nurse it is more than emptying urine. The nurse is making a connection with the patient, assessing a person's response to their illness, measuring fluid balance by observing input and output amounts, and noticing the overall appearance; is the person dehydrated and in need of fluids, and should the physician be notified? (Cameron, 1995)

Still a further example might be that of wound care. Dressing a wound can be more than simply cleaning it and placing on a bandage. It requires assessment skills and a sterile technique, something that is difficult to comprehend without an understanding of microbiology and bacteriology. Nursing educators say it takes them hours to teach such a technique to their students, and these students already have the inherent knowledge as a part of their professional competency training. Teaching sterile technique "on the job" is made much more difficult without this prior knowledge. As well, it has been found that the incidence of wound infection significantly increases when dressings are done by non-nurses trained on the job (Cameron, 1995).

Some of the literature speaks to the education and training of a multiskilled generalist, with entry-level knowledge and training in two or more disciplines. In the discussion around this topic, it is argued that multiskilled generalists, however easily they can learn basic tasks or mimic psychomotor actions, cannot emulate the tacit knowledge that develops over years of specialized study and practice. A further argument against generalists is that specifically educating them as such might not be as effective as developing multiskilled workers through "add-on" type programs. A nation-wide study in the U.S. discovered that clinical skill combinations were often determined by each institution's individual needs. This suggests that there might be a greater demand for "add-on" programs and lesser demand for the multiskilled generalist (CAMRT, 1995). There are also suggestions that these "add-on" programs would be most effective, and would avoid any concerns about ethical practice or the erosion of clinical care and expertise, by making multiskilling an option only for those who currently have a solid background in health science education (CAMRT, 1995).

The literature points to some further concerns about multiskilling. If is to be a successful, acceptable practice throughout health care, not only do workers, management and the professional associations who provide certification to workers have to be comfortable with the concept and implementation of a mix of multiskilled workers in the health workforce, but the patients who receive the care must also feel comfortable that they are receiving quality care from a competent and qualified practitioner. Brenda Cameron, an assistant nursing professor, says patients have the right to know the qualifications of who is taking care of them (CAMRT, 1995; Task Force on Support Personnel, 1996).

Needham (1996) cites studies that show the benefits gained by employing a fully qualified workforce. One such Canadian study by Buchan (1993) argues that with an all RN staff there is less 'non-productive' time, a reduced rate of sickness and patient throughput is much quicker. In 1994, the Royal College of Nursing reached a conclusion that "qualified nurses are cost-effective and make a significant difference to the quality of care, mortality rates, length of stay and cost whether in hospital services or in the community." The College says further, "the higher productivity of qualified staff directly results in lower unit labour costs."

American Health Consultants (1995) talk about the possible difference in work ethic between UAPs and licensed providers, and point out that UAPs may have higher rates of absenteeism and turnover, and that the obligation nurses feel toward their patients may not be shared by UAPs.

Those who believe in the concept of an all RN staff say that it provides the best quality of care (Blegen, Goode and Reed, 1998), the most flexibility, it is the most cost-efficient, and that there are no problems with assigning duties to staff (Koch, 1996). In other words, all staff members are capable of performing all functions and there is no concern for patient safety in the hands of unqualified staff.

Concerns similar to those voiced by the nursing profession regarding the use of support personnel, are heard in other professions as well. Issues of professional supervision and accountability, and legal and ethical considerations also surround the use of aides in occupational therapy (Russell and Kanny, 1998) and physical therapy practice (Rogers, 1991).

Conclusions from the literature

One of the most interesting conclusions that can be drawn from the multi-skilling literature is its preoccupation with UAPs. There is very little empirical evidence that compares, for example, the differences between RPNs, RNs, and LPN. What little literature there is on these two occupations is problematic because of the different training, licensing and regulatory environments for LPNs from jurisdiction to jurisdiction. (See the discussion on **Nursing Skill Mix** beginning on page 37.)

Saskatchewan is no stranger to the use of multiskilled providers. Combined Laboratory X-Ray Technologists are multiskilled workers who have been working for many years in Saskatchewan and Alberta rural hospitals, because the lack of volume or range of activity existing there would not make it feasible to hire both a laboratory and radiological technologist (CAMRT, 1995). This of course supports the notion that what works for one organization, or in this case geographical area, may not be appropriate for another. Therefore, a generalist approach may not be the most logical answer to this multiskilling dilemma.

There is a good deal of anecdotal evidence promoting the use of multiskilled providers. For example, Wagner (1995) describes the reaction of the Women's Service Line at Owensboro Mercy Health System in Kentucky to the need to work with fewer staff and greater acuity. It was found that some units experienced lulls while others were busy, for example after several babies were born the labour and delivery unit would be quiet and the postpartum unit would be overflowing. They decided their best solution would be to cross-train the nurses in all four maternal/child units so that during periods of lulls and overflowing qualified and trained nurses could be swapped among the units. This prevented them from taking needed staff from elsewhere in the hospital that did not have the necessary skills or expertise. To accomplish the training for this manuals for each unit were put together using policies and procedures already being used in each unit and including other unit specific educational material. Each person took classes and was provided a preceptor to "learn the ropes" from. Training was ongoing, with monthly unit specific educational programs to which everyone was invited.

There is much anecdotal evidence in the literature describing many organizations' positive outcomes with using skill mix. They say patients benefit from the extra tasks that the unlicensed assistants do that nurses do not have time for and consequently patient morale increases. Nurses in turn have more time for nursing functions, such as assessment and care planning.

This is true in other health professions as well. In pharmacy, the use of supervised pharmacy technicians increases the quality and efficiency of pharmaceutical care by reducing the time pharmacists spend on technical activities and allowing them to focus on patient drug-therapy tasks for which they are uniquely trained (Rough, Reid-Ganske, Thielke and Ploetz, 1996; Ploetz and Woller, 1992). In similar fashion, support personnel like physical therapist assistants (Ellis, Connell, and Ellis-Hill, 1998), occupational therapy aides (Ramsay, 1995), and surgical technologists (Armstrong, 1996) are used to assist their professional counterparts.

The literature is quite clear that unlicensed personnel must never be allowed to perform any functions that by law must only be performed by licensed providers. However, there is little disagreement that the organized use of properly trained unlicensed personnel can be beneficial to organizations, patients and health care practitioners. As one speech-language pathologist freely states, "once our attitude changes, the help we receive from support personnel will prove to be immeasurable" (Kimbarow, 1997).

At best, there is no consensus in the literature regarding the growing trend towards multiskilled providers.

The Labour Market

How does health care fare in comparison?

Labour market statistics are difficult to find in a manner that makes health care directly comparable to other industries. There are significant labour market shortages in several occupational categories around the province. The 1998 Saskatchewan Health Employer Survey (2000) notes that the Southeast Health District has a great need for Combined Technicians and LPNs. Human Resources Development Canada (HRDC, 2000) notes that Estevan has shortages of Retail Salespersons and Sales Clerks, Truck Drivers, and various categories of Oil and Gas Well workers. Similarly, the 1998 Saskatchewan Health Employer Survey indicates that Regina Health District needs LPNs, RN's, Podiatrists, Occupational and Physical Therapists, and nuclear medicine technologists. HRDC Canada also indicates that the City of Regina is suffering a shortage of Computer Systems Analysts and Programmers, Cooks, Heavy-Duty Equipment and Motor Vehicle Mechanics, and Truck Drivers. In fact, In the spring of 1997 there were media reports that up to 1,000 truck drivers were required in Saskatchewan (HRDC, 2000)

The Conference Board of Canada (Murphy, 2000) reports that 83 per cent of Canadian organizations surveyed are experiencing shortages of skilled labour. Their report notes that skill shortages pose a major threat to the competitiveness of Canadian industry and the forecast is that these shortages will increase as baby boomers head towards retirement.

The Saskatchewan Teachers Federation reports that over half of the province's teaching force is over 40 years of age. Furthermore, in the next 10 to 15 years a substantial number will retire thus diminishing the supply of teachers in the province. Unlike most health care occupations, only 15 per cent of percent of teachers work part-time. (HRDC, 2000) Similarly, the average Canadian steelworker is 48 years old and has 21 years of experience. A study, cited by the Conference Board of Canada predicts a loss of one third of the steel workforce and 45 per cent of all steel related trades in the next 5 years. (Murphy, 2000)

HRDC (2000) reports that across Canada, the number of jobs for computer programmers and systems analysts have almost doubled between 1992 and 1997 (swelling by 92 per cent, to 267,000, compared to 9 per cent employment growth for the economy as a whole). New technologies, such as the rapidly growing Internet, the expansion of internal computer networks in large organizations, and Y2K preparations have all contributed to this expanding job market. HRDC cites a February 1999, Information Technology Association of Canada (ITAC) estimate that Canada's high-tech industry will create 30,000 jobs over the next two years (surpassing a previous estimate of 20,000 job openings by the Software Human Resources Council). ITAC anticipated strong demand for project managers, senior software developers, technical consultants and systems engineers.

Wareham (1999) reports an estimated 20,000 unfilled information technology jobs in Canada. Industry experts predict the number will grow to 50,000 in the next three years.

All this is not to underplay the seriousness of shortages in health care, but to point out that in an expanding early 21st century economy, labour shortages and ageing workforces are not unusual and the health care sector is not alone in facing retention and recruitment challenges. Any approach to retention and recruitment shortages in health care must be made in the context of the overall economic climate.

There are several sources that indicate shortages of health care professionals and, especially, Registered Nurses. RNs represent the eighth largest occupational group in Saskatchewan with employment of over 8,000. Employment declined between 1989 and 1994 but HRDC projections to 2005 indicate that jobs will grow at an average rate. An estimated 2,600 job openings will be available and almost 60 per cent of these will be replacement, rather than new, jobs. HRDC predicts that the exact growth will be determined by the extent of health care reform and the expanded role of nurses in community-based health care delivery. (HRDC, 2000)

The Nursing Shortage

The debate as to how serious the nursing shortage is and how to cope with its repercussions is one which goes back many years. As early as 1968 Helen K Mussallem (p.35), Executive Director of the Canadian Nurses' Association observed that, "Since 1950, the percentage of qualified women seeking entry into the profession has declined by more than 50 per cent and the rapid decline is continuing." Although Mussallem concluded that there had been a consistent shortage of skilled human resources for two decades, she posited that the problem in nursing was not so much a shortage of qualified nurses as, "such a colossal waste of nursing skills, from poor utilization of nursing time, turnover of staff, emigration and non practising personnel, that it results in an actual shortage of available nursing hours." Ironically, this article, first published in 1967, echoes the present day discussions of health human resources issues.

The most frequently cited source indicating a shortage of Registered Nurses in Canada is the report done by Eva Ryten under contract for the Canadian Nurses Association. Her report used three different scenarios to predict a shortage of nurses of 59,000, 86,000 or 113,000 by 2011.

CIHI, the Canadian Nurses Association and Statistics Canada report an ageing nursing workforce with fewer people (and especially younger people) entering the profession. In fact, 25 per cent of practising registered nurses are over 50 years of age and this proportion is increasing. The number of practising registered nurses under the age of 29 has declined by 32 per cent in the period from 1993 to 1998. Nurses' location of work has changed too. In 1998, 62 per cent of registered nurses worked in acute care settings as opposed to 67 per cent in 1993 while the percentage of registered nurses working in community settings and home care increased from 9 per cent to 12 per cent. Nearly 10 per cent of new registered nursing graduates emigrated to the USA between 1995 and 1997. (Spurgeon, 2000)

Nursing Labour Market Analysis

Commissioned by the Departments of Post Secondary Education and Health, Doug Elliott's report, **Labour Market Analysis: Saskatchewan Nursing** examines the factors that affect nursing supply and demand in the province. The study found:

- The proportion of new RN graduates with full time employment reached a high of 71 per cent in 1998 and continues to increase.
  - The overall proportion of RNs and RPNs working on a full time, full year basis has remained stable for the last 5 years.
- A decline in the number of RNs leaving the province to find work. More leave Saskatchewan than enter. In 1991 428 left. In 1999 186 left.
- Areas of Responsibility
  - A decrease of 20 per cent in the number of nurses working as managers or supervisors
  - A 4 per cent increase in the number of nurses providing institutional or community care.
  - A 10 per cent decrease in RNs providing medical / surgical care
  - A 19 per cent decrease in RNs providing paediatric care
  - A 5 per cent decrease in RNs providing maternal care
  - A 68 per cent increase in RNs providing community health, ambulatory, home care and occupational health services (includes an 86 per cent increase in home care nurses)
  - A 15 per cent increase in the number of RNs working in operating rooms, emergency rooms and critical care units
  - A 35 per cent decrease in RNs who reported working in several different settings which Elliott interprets as possible indicating a decrease in workplace "flux" since 1993.
- Increases in enrolment in NEPS
- Saskatchewan has 8.5 RNs per 1000 pop. The national average is 8.4
- Between 1993 and 1998.
  - The number of Saskatchewan RNs has remained stable at approximately 8400
    - The national supply of employed RNs declined by 3.3 per cent during the same period.
  - The number of RPNs has declined from 1172 to 1112
  - The number of LPNs has declined from 2600 to 1900
- The vacancy rate for RNs was about 1 per cent until 1998 when it suddenly increased to 3.3 per cent
- RNs tend to leave direct patient care nursing after they reach 55 years of age. Many nurses are near or past that age.
  - LPNs are also ageing as a group, but tend to stay in the profession longer

    - The number of RN grads reached a low in 1999 but is increasing.
- 52 per cent of Saskatchewan residents educationally qualified as nurses are working in health care occupations. National average is 51 per cent.
- Concludes that the number of RNs and RPNs that need to be recruited in the next 5 years is between 105 and 331 per year. The number of LPNs that need to be recruited in the next 5 years is between 64 and 129 per year.
    - We need between 130 and 400 seats per year in NEPS to meet this need.
        - We are up to 260 now.
    - We need between 80 and 160 seats per year in the LPN program to meet the need.[8]
        - The LPN program is offered at SIAST, Regional Colleges and the Dumont Technical Institute. The total program capacity has been 48 for some years with recent large increases.
            - In 1998-99 the seat capacity was 72 (64 at SIAST and 8 at regional colleges).
            - In 1999-2000 the seat capacity was 128 (64 at SIAST, 48 in Regina and 16 in PA); (64 off delivery campus, 16 at Dumont Technical Institute and 48 at regional colleges around the province).

Elliott found that overtime in hospitals has been rising slowly in hospitals and faster in long term care institutions during the 1990s, but is only between 1 per cent and 1.4 per cent of payroll. He conceded that much overtime may be taken as time off in lieu of pay. Another possibility is that it is not compensated.

One of the most interesting aspects of Elliott's report is the finding that the overall supply of nurses in Saskatchewan has been fairly stable. The demand for nurses, however, seems to be increasing.

Shortages of other occupations

Managers indicated that, besides the various types of nurses, other hard-to-recruit categories are:

- Early childhood psychologists
- Pharmacists
- Occupational and Physical Therapists
- Information Technology people
- Accountants and other financial people
- Ultrasound technicians and Diagnostic Imaging technicians
- Podiatrists

Often the total number of these providers required in a district is small and this makes their absence all the more critical.

One difficulty occurs when an occupational group is represented by more than one union. For example, the current SEIU collective agreement has better wages for diagnostic imaging than CUPE's. Some districts whose ultrasonographers, MRI, x-ray and laboratory technicians are represented by CUPE have difficulty competing with their neighbours.

As one Human Resources manager contributed, "The biggest recruitment challenge we've got is the widespread shortages in the labour market."

---

[8] Elliott's seat numbers are based upon the assumption that the acquisition of new practitioners would come exclusively from our educational institutions.

The example of Physical Therapists is an interesting one. Data from the Saskatchewan College of Physical Therapists indicate that the number of physical therapists licensed to practise in Saskatchewan has increased each year adding 129 from 1993 to 1998. Yet Saskatchewan Health data indicate that the vacancy rate has remained steady.

Supply of Physical Therapists - Saskatchewan

Year	New Licenses	Not Renewing	Net Gain	Cumulative	Vacancy Rate
1999/2000	60	36	24	129	No Data
1998/1999	63	38	25	105	8%
1997/1998	43	30	13	80	7%
1996/1997	50	43	7	67	3%
1995/1996	53	31	22	60	6%
1994/1995	55	25	30	38	5%
1993/1994	48	40	8	8	7%

Sources: Saskatchewan College of Physical Therapists and Saskatchewan Health

Nursing Skill Mix

As part of our mandate, Health WORCS reviewed the extensive literature on nursing skill mix. More than 150 articles and book chapters were reviewed. Many non registered nurse comparison groups fall under the general category of "nurse extenders" or "unlicensed assistive personnel" (UAP). UAPs consist of over 65 different categories of personnel with varying levels of expertise and training who assist in the care of patients (Krainovich-Miller et al, 1997) Much of the literature is critical of the use of UAPs For example, one study concluded that "Results suggest that training... of personnel was inconsistently planned, lacked comprehensiveness, and often was done on an informal basis." (Salmond 1995, p.27) Some of the opposition to UAPs is uncompromising in its viewpoint and is more editorial than research based. (see, for example, the article by an assistant editor of **The Canadian Nurse**, "Delegating Away Patient Safely" which begins with, "You can't remove thousands of registered nurses from the Canadian Health Care System, fill the gaps with unlicensed workers, and expect safe, quality patient care to remain." (Sibbald, 1997 p. 22) There are several very good literature reviews including those by Bernreuter & Cardona (1997a; 1997b), Shamian & Thomson (1999), Krainovich-Miller et al (1997), Dewar & Clark (1992) and Krapohl & Larson (1996) so we will not attempt such a comprehensive report here.

Much of the literature is anecdotal in nature. Sometimes these explain how to make the transition to nursing assistants while retaining a satisfied RN staff (see, for example, Kostovich 1994; Neidlinger et al 1993; Reisdorfer et al 1993). Some emphasize the positive effects of the use of LPNs or aides on alleviating the RN shortage and improving job satisfaction (See, for example, Lewis 1993; Hegland 1993) Other articles clearly identify nurse extenders as a threat to RNs. (See, for example, Dimon 1995; Sibbald, 1997; Snell 1998; Clay 1997)

Some of the empirical research presents conflicting conclusions. For example, Minyard et al (1986) found that the more qualified the nursing personnel, the greater the productivity. Eastaugh (1990, p.561), on the other hand, found that "productivity varies widely among hospitals as a function of staffing patterns, methods of organization, and the degree of reliance on nurse extender technicians. Nurse extenders can enhance the marginal value product of the most educated nurses as the RNs concentrate their workday around patient care activities. The results suggest that nurse extenders free RNs from the burden of non-nursing tasks."

There is a dearth of high quality empirical evidence regarding the effect of varying skill mix from all-RN teams, but there are a few notable exceptions. Shamian and Thomson (1999) summarize this literature very well. Much of the literature suggests that quality is proportional to the ratio of RNs[9] to other nursing caregivers in long term care (e.g. Munroe 1990) and hospitals (e.g. Blegen & Vaughn; 1998; Reed, Belgen & Goode 1998).

For the most part, the few high quality empirical studies are fraught with methodological weaknesses which limit the usefulness of their conclusions. Furthermore, most studies compare Registered Nurses with all other categories of nursing personnel including LPNs, and LPNs themselves vary in qualifications, education and competencies from one jurisdiction to another (see, for an Alberta example, Elliott 1995). Other methodological problems occur when the data is collected in one hospital or even on one ward, thus limiting generalizability (e.g. Reed, Belgen & Goode 1998; Blegen, Goode & Reed 1998). Where multi hospital studies are done (e.g. Blegen & Vaughn 1998) there is a problem with nesting of data and the inconsistent methods and reliability of data collection between units and hospitals. Given these limitations, it is difficult to draw a conclusion beyond a conservative one. It can be said that the literature suggests that the quality of care may suffer inversely with the proportion of RNs to alternative nursing care providers, but the cost-benefit ratios are not easily articulated. In times of shortages, it may be necessary to sacrifice a degree of quality in order to maintain access to services or control costs and this trade-off may be justifiable. In any case, there is no evidence that Saskatchewan LPNs (or their equivalent in other jurisdictions) detract from the quality of care in any way.

Magnet Hospitals

The term 'Magnet Hospitals' was first given to a group of American hospitals that were particularly successful at retaining and recruiting nurses in the 1980's by the American Academy of Nursing. Hospitals were selected because: a) nurses within the hospitals considered them good places to work, b) the hospitals were able to recruit and retain, as evidenced by relatively low staff turnover and vacancy rates, and c) the hospitals were located in areas where there was significant regional competition for nursing services. Presently, American magnet hospitals are designated by the American Nurses' Credentialing Center's Magnet Nursing Services Recognition Programme. (Scott et al, 1999; Fuszard et al 1994a)

---

[9] No distinction is made in the literature between RNs and Registered Psychiatric Nurses

Preliminary research studies (cited in Scott et al, 1999) indicated that magnet hospitals had nurse leaders who:

- Were visionary and enthusiastic
- Were supportive and knowledgeable
- Maintained high standards and high staff expectations
- Valued education and professional development
- Upheld positions of power and status within the hospital
- Were highly visible to staff nurses
- Were responsive and maintained open lines of communication
- Were actively involved in state and national professional organizations.

Shared organizational attributes of magnet hospitals were (Havens & Aiken 1999, p.15):

- The nurse executive was a formal member of the highest decision making body in the hospital, which signified the high priority that hospital administrators placed on nursing.
- Nursing services were organized in a flat organizational structure with a few supervisory personnel, rather than a pyramid structure composed of many layers.
- Decision making was decentralized to the unit level, giving nurses on each unit as much discretion as possible for organizing care and staffing in a manner most appropriate to the needs of their patients.
- The administrative structures supported the nurses' decisions about patient care.
- Good communication existed between nurses and physicians

Although some of the magnet hospital literature reports that some magnet hospitals have moved towards all RN staffing (Havens & Aiken 1999) other authors emphasize the importance of primary nursing including the use of associate nurses who work in partnership with the primary nurses (Scott et al, 1999).

While the magnet hospital concept is American in orientation there is some opinion that it may be transferable to other countries. Buchan (1999) has considered the concept's applicability within the British NHS and has concluded that many of the trends which make magnets relevant in the American context are also present in the British system. Buchan points to the ANCC template and suggests that it could become an international standard for accreditation of magnets. While there are some notable differences between British and American values in health care, specifically as they relate to general taxation funding of a universal public system, Buchan concludes that the trends in hospital level organization and workforce deployment are similar. Indeed, these trends, including a flattening of organizational structures may be seen in Saskatchewan as well. There is good reason to suppose that the magnet hospital concept can be tailored to a Saskatchewan model.

There is very little research that has evaluated whether magnet hospitals actually lead to better patient outcomes (two notable exceptions are Aiken Smith & Lake 1994 and Havens & Aiken 2000 which link magnets to lower mortality rates) and it is difficult to draw firm conclusions from it. There does seem to be ample evidence, however, that magnet hospitals lead to better retention, recruitment and job satisfaction. The research basis for concluding that magnet hospitals are sustainable and have advantages over non-magnets is weak, but magnet hospitals are not entirely without promise. (see, for example, the discussion by Buchan 1999)

Rural Magnet Hospitals

Fuszard et al (1994a; 1994b) have attempted to place the concept of magnet hospitals within the reach of rural hospitals. This discussion has great relevance for a province like Saskatchewan. As a caveat, the 10 rural hospitals included as magnets in this Georgia study ranged from 37 to 96 acute care beds with an average of 56 beds. Fifty percent offered obstetrical services. This definition rules out many Saskatchewan facilities a priori. None of the rural magnets had the second characteristic initially used for magnets, i.e. the hospitals were able to recruit and retain, as evidenced by relatively low staff turnover and vacancy rates and they had an average 15 per cent RN vacancy rate[10]. Seven out of the ten had a RN vacancy rate of 8 per cent or less and two indicated that staff vacancies are frequently for nurses with highly specialized educational backgrounds or experience. Half the rural magnets had LPN programs[11], all had baccalaureate nursing programs and one was affiliated with a masters degree program. Fuszard and her colleagues concluded that it was possible to apply principles of magnet hospitals to rural facilities but were not able to establish any definitive outcomes regarding how effective these facilities are at retention or recruitment beyond a suggestion that there might have been some advantage over non-rural magnets.

Typical responses to recruitment and retention difficulties

Recruitment

Murphy (2000 p.5), in a survey of 500 medium and large Canadian companies found that 48 per cent had increased recruitment resources over the last 3 years. In addition, he found that organizations are concentrating their efforts in three areas that they consider to be essential to their ability to recruit:

- "marketing the organisation as a great place to work,
- providing a learning environment (increasing training and development expenditures, and
- augmenting student programs (e.g., co-op programs, internships)."

---

[10] Vacancy rates were influenced by one hospital which, at the time of the study had filled RN positions of only 30 per cent.

[11] LPNs outnumbered RNs at four of the 10 rural magnet hospitals.

Murphy (2000, p.7) identified which strategies actually worked and found that statistically significant predictors of recruitment success were:

1. Augmenting student programs
2. Providing a learning environment
3. Using anticipatory hiring practices
4. Seeking recruits from outside Canada
5. Involving employees in the recruitment process

Marketing the organization as a great place to work was not an effective strategy. The Conference Board of Canada (Murphy 2000) conducted focus groups with post-secondary students and found that the five critical factors in choosing an employer were:

1. Compensation
2. Challenging work
3. Work-life balance
4. Recognition / respect
5. Advancement opportunities

Retention

The Conference Board of Canada study (Murphy, 2000 p.11) found that 48 per cent of firms had increased resources over the last three years devoted to employee retention. Organizations saw the following as contributing most successfully to employee retention:

- Identifying high potential employees,
- Improving the organization's understanding of the needs and values of employees,
- Strengthening succession management systems, and
- Improving responses to work-life balance issues

The results of the study, however found that the following five factors were actually predictors of retention success

1. Holding managers accountable for retention
2. Having a mechanism for identifying high-potential employees
3. Having a clear understanding of the needs and values of employees

4. Tailoring retention strategies to life-cycle stage

5. Having effective succession management systems

Employee focus groups performed by Murphy (2000 p.13) identified a slightly different perspective on the factors that retain them:

1. Challenging work (including opportunities for learning)

2. Work-life balance

3. Recognition

4. Salary (steady movement through pay bands)

5. Change (opportunities for vertical or lateral movement)

Chapter

6

What We Heard

Front Line Providers and Supervisors[12]

We talked to 238 front-line health providers in nine health districts in the southern half of the province. In this section we discuss what they told us. We focus on the things we heard that were consistent across districts, workplaces, and occupational groups. We also highlight the differences—issues raised that were unique to districts, workplaces, or provider group. Discussion of the groups' recommendations for addressing the challenges concludes the section.

Challenges to Recruitment and Retention

The discussion group participants we talked to identified challenges to recruitment, retention, and job satisfaction in three areas: *how the work is organized*, *how the workplace is managed*, and *how the external environment affects the workplace*. The relative weight placed on each varied from district to district, and across groups. Most of the groups' discussion focused on job satisfaction and employee retention issues. Most participants made it clear they loved their work and believed their jobs were important. They said they derived the most satisfaction in their work from providing quality patient care. Dissatisfaction stemmed from their inability to provide quality care consistently.

How the work is organized - Workload

Workload issues were by far the most significant challenge to employee retention and job satisfaction raised by discussion group participants. There was discussion in all of the groups about being overworked, being too busy at work, or having to deal with an increasing number of work tasks and responsibilities. Front-line supervisors said there was never enough time to get all the work done and that the increased workload was felt at all levels, including among supervisors, managers and VPs. One manager reported: "My job is crazy sometimes, challenging and crazy…I have a problem, I can't seem to get anything done".

Many front-line care providers from both institutional and community settings said with their current workload they were "run ragged" and "stretched too thin". They said there was never enough time to get everything done; there was always "more work than can be done in one day"; and that many 12-hour shifts were more like 13 or 14 hours. One participant compared work in home care to that of a "machine or a robot" another admitted he was always "hopelessly behind".

---

[12] This section was contributed by HSURC and was prepared by Joanne Hader, Senior Research Officer.

Participants identified several reasons why they found the workload so overwhelming. Front-line staff said they are continuously called upon to do many non-patient care tasks such as attending meetings and doing paperwork, learning new technologies, and orienting and mentoring new staff. They said they are also expected to do work that is not 'theirs' such as clerical and reception work. Several participants indicated they had been called on to do maintenance work such as fixing the leaky plumbing or routine housekeeping and cleaning tasks, such as dumping the garbage. Most agreed, "When others are busy the work gets downloaded on front-line workers".

Participants believe the workload is also overwhelming because people in their care are now more acute than in the past while staffing levels have decreased, not increased accordingly. In addition to the increased acuity of clients in all settings, participants told us sick staff is not being replaced, positions are left unfilled, and casuals are not available to work. They said this is particularly problematic in rural districts where many of the casual staff work in several facilities.

> "Our casuals, one works full-time in home care so she's not available very much. Our other casual is working in Alberta and she's been gracious enough to come back the odd day so she's travelling half a province over to fill in for us because we're desperate".
> "...and the DOC is unable to find anyone to cover and they are phoning and phoning ...it stresses everybody else out when you have to work short or have to work six in a row".

Several front-line managers expressed their frustration with having to cover shifts when casual replacements cannot be found. Casual staff expressed their frustration with being called repeatedly to come to work and with "getting in trouble" when they refused work.

Compounding workload problems, many participants said they often had to attend meetings or training sessions on their days off or they were called in to work overtime. "People are doing buckets of overtime, especially nurses". People said they have been called back to work when on holiday or have been forced to file a grievance when denied a family leave day. Many said they go to work when they are sick themselves because they "feel guilty" knowing there is no one else to cover for them. In some districts it is not uncommon to be told "you can have them [your holidays] if we have somebody to replace you". Several participants expressed their frustration:

"I feel guilty for taking holidays or calling in sick"
"I will trade all my shifts, it makes it easier for me and the rest of the staff".
"You feel responsible. You call in sick that means somebody else has to do a fourth or fifth shift in a row or they don't get a break".
"You don't stay home cause you're always thinking well they don't have anybody to replace me".

As a result of working short staffed, being overwhelmed by non-patient care work, and working sick and overtime, front-line health care workers report they are not getting an opportunity to rejuvenate and they are "wearing-out".

> "What's gonna happen when you're tired of overtime and you're gonna say NO...eventually we're going to burn out".

Not only are front-line workers getting burned-out but they also said they are frustrated by the difficulty they are having prioritizing. Many participants bemoaned the fact that they had no time to "do a satisfactory job", to provide quality patient care, or to treat the "whole" patient.

> "You go home feeling like, 'Did I make someone feel good today, like what did I really accomplish?'"
> "It is all very stressful when you are not able to provide the kind of care that you want."

Other participants were more troubled by workload issues. They expressed concern that heavy workloads were jeopardizing continuity of care in home care and putting patients and staff "at risk". One participant said the situation could even become "dangerous" for patients if not checked. Another suggested that working short-staffed was dangerous because it seriously hampers a facility's ability to respond to an emergency.

How the work is organized - The Work Environment

A second area in which discussion group participants raised a significant number of issues relevant to both recruitment and retention related to the environments in which people worked—to the health (or lack thereof) of their workplaces.

We heard that, in general, change and amalgamation have been unsettling for front-line health workers and managers, and many fear more change is on the horizon. Participants said they hear rumours about districts amalgamation and about the smaller long term care facilities not being cost-effective and therefore closing. The fear of more change is heightened in small rural districts, "we just figured out how things work, now they are going to change things again". Managers told us they are not equipped to adequately help staff deal with change.

Front-line managers from two health districts told us how their work sites are characterized by an atmosphere of confrontation, especially since the strikes last year. Several managers said they believe there is general feeling of discontent with working conditions among the staff.

"I have found the union to be very confrontational…its just you made a mistake and I'm gonna get you".
"I think there's an atmosphere of union unrest and it's infected my department".

The front-line staff described specific aspects of the work environment that illustrate why this discontent may pervade the health workplace. Both the institutional and community staff said some buildings in which they are expected to work and provide their programming are deteriorating. Community program staff in some districts described shared and cramped office space located wherever they can be fit in. Those required to travel extensively in their work said that at times they fear for their safety when out on deteriorating country roads, alone.

In many districts, participants told us that they believe insufficient resources are put towards making sure equipment is available for them to do their jobs. They reported they are often forced to work with old, outdated, and occasionally hazardous equipment or purchase their own materials such as teaching aides. Some suggested that in their district it was not clear how it was determined who could access equipment such as computers and email accounts.

In addition to issues about physical workspaces and equipment, most discussion groups raised a number of concerns about the social environments in which they work—about the people interactions at work. This social dimension of the health workplace appears to be significantly influenced by the composition of the staff, the organization of the staff (i.e., into teams), and interactions among staff and peers on the job. Patients and their families, not surprisingly, also influence the workplace.

Several discussion group participants said they were quite unhappy about the lack of on-site management and the constant revolving door of managers in their districts. Some also expressed concerns about how a constantly changing staff could influence continuity of care. Others expressed concerns for patient care when districts seemed to be constantly replacing staff with less skilled workers (for example, replacing RNs or LPNs with aides in long term care facilities).

We heard discussion about work teams in most of the discussion groups. Many participants spoke of a lack of support they now felt from their teams, or highlighted problems with teams such as the exclusion of vital team members (LPNs). One participant from the acute care setting felt quite strongly that their job satisfaction was closely linked to opportunities to work with functional and consistent teams.

"I know for myself with job satisfaction that goes up and down as my team goes up and down, because I can't do my job if my team isn't able to do their job or aren't there to do their job…if the ward clerks not there…it makes my job twice as hard cause I'm doing their job as well as taking care of my job".

In discussing staff interactions in the workplace, participants spoke passionately about the break down in their relationships stemming from changes to, and downsizing in, the health care system. Many said they work for invisible managers that do not support them. Others adamantly defended their district management and said they were "approachable and easy to talk to". In more than one group we heard about staff fighting with each other over shifts; low morale and staff bitterness towards each other in a "survival of the fittest" health workplace; and cut backs, bumping, "increasing resentment", and job insecurity. In some rural areas, health professionals from different communities vying for the same scarce resources said colleagues were "sometimes supportive, sometimes not". Only two groups commented on physicians' attitudes and interactions in their workplace.

In most of the groups we heard about the importance of peer–support in the health workplace. Participants told us that peer support was vital both for both immediate debriefing or feedback and in the longer term for maintaining networks and keeping up with changes in the professions.

"I am the only counsellor in the health district. Because of the confidentiality issue of counselling there's really nobody that I can vent to...That for me really increases [the stress] and I find on occasion I've taken it home with me".

"What I find is that in the rural area it's very challenging when you are on your own because you have to make decisions usually without very much ability to rebound off other individuals or other [professional] so when you get a very difficult client..."

Some participants expressed concern about how health reform has changed the lines of communication and has reduced opportunities for peer-interaction, for example among the dental health educators or public health inspectors. Others, particularly community professionals who were the sole providers of a service in a district or in a service area comprising several districts, reported on how they have created innovative mechanisms for interaction despite geographic barriers. For example, they told us that in some small districts all the community-based health professionals meet regularly over coffee (and management supports this informal networking).

Finally, we also heard about how satisfaction with the work environment is influenced by patient expectations and demands. For example, we heard about patients discharged from base hospitals that expect to receive physical therapy daily as they did in the larger centres. When this service is not available or not offered daily in their local community, both patient and staff are frustrated.

How the work is organized - The Work Available

The work available to people in the health professions was the third area in which discussion group participants raised a number of concerns. Most of these directly affect health districts' ability to recruit. Key issues raised include: job security and the availability of permanent positions and full time jobs; compensation, benefits and wage parity; and the amount of autonomy and flexibility that the work allows.

All the groups told us they believed there were not enough permanent or full-time positions in the system to attract new people to their districts. In some districts we were told there were a number of available, unfilled positions that are not offered full-time and that "people won't move here for casual jobs". Participants also told us that the lack of permanent positions in their workplaces and the casualization of the workforce have reduced job satisfaction (and therefore influenced employee retention), created scheduling nightmares, resulted in inconsistency in patient care, and virtually eliminated job security for many front-line health care providers.

"I've got student loans to pay off but there's not a permanent job".
"We have got nurses in the system who are wanting to work full-time hours and they are not getting them...we have got four people right now in our department who want to work full-time...we have got people who are working in video store half the time".

In addition to the availability of permanent work, discussion group participants talked about compensation and the influence of perceived pay inequities on job satisfaction and recruitment. They expressed concern about differences in pay and benefits between the health districts within Saskatchewan and between the different (mainly western) provinces. Some groups discussed pay and benefits within professional groups where the distribution of both did not appear to be equitable or related to education differences or reflect experience. They told us that "experience doesn't seem to count for anything anymore" and "more education increases the work and responsibility" for some groups, while "LPNs with extra courses don't earn any extra money".

Discussion group participants also talked about the influence of autonomy and control on workplace satisfaction. Many front-line health professionals, particularly those working in the community settings, enjoyed the autonomy and flexibility they have at work. They did suggest, however, that a new recruit might find the independence of being a sole rural provider a bit daunting. Several groups raised the issue of the importance of flexible work arrangements both for new recruits and for existing staff as they near retirement age.

How work is organized - Work Roles

The final area related to the organization of work in which participants raised a number of issues, relevant to both recruitment and retention, involved work roles and skills—the requirement of being a generalist in a rural setting and health care providers' ability to use the skills they have.

In most of the groups we conducted outside of large urban centres, participants talked about how 'varied' their work was—how one had to become a "generalist in their speciality"; how all front-line care providers, including aides, have to be generalists and had to know a lot about everything. One participant joked with another who was lamenting the diversity of her work: "They never told you you needed a tool-belt, eh?"

Many said they looked forward to the diversity in their professional work because it makes it interesting, yet they also found it stressful because you can be caught unprepared.

"The job is definitely challenging and every day you have to start the day off with the idea that nothing is going to be the same as it was the day before…so you have to be very flexible and have to be ready to roll with the punches and adjust…if your garbage is full you get to dump it, so you get to be a jack of all trades".

"To be a single practitioner, to be a little bit of everything is a challenge…the information is not always at the tip of your tongue".

In several discussion groups, front-line health care workers expressed their frustration with not being able to do what they have been trained for.

"In an acute care setting the LPNs are trained to do a vast majority of procedures, but a lot of institutions will not allow us to do them. However, on the other side of the scale it [the institution] is increasing the RNs job and making it more stressful for her. If they would allow us to do some of the jobs we are trained to do such as possibly dressings…that would free her to do more RN jobs which LPNs cannot do…and the day would be less stressful".

Other groups talked about staff that spent their own money upgrading their education and are now unable to use all their new skills or are not compensate for their upgrading.

"I did an additional training course, I became a certified diabetes educator and I did it all on my own time, at my own expense, didn't get a raise for it, didn't get recognition for it".

Yet others reported how workload pressures have forced them to focus on acute care, when "my job supposedly should be far more prevention". Some told us about how the psychosocial care they provide is devalued when management constantly tries to get them to focus on measurable outcomes.

How the workplace is managed

In addition to raising a significant number of issues about workplace organization, discussion group participants also made a number of observations about the management of the health workplace.

Some participants said their managers "support us" and "are a voice" for us. They said if managers aren't there for you it is because they are just as busy and overworked as their staff. Most participants, however, talked about a management that was "out of touch" with their employees, particularly the "invisible" senior managers. Many expressed their frustration with managers that have "no clue what I do"; managers that have unrealistic expectations about workloads or about the amount of time those in the community spend travelling; or managers that have no understanding of their employees professional needs.

Some groups told us that their frustration with management stemmed from a "program management" system in which they work for managers who have never done their job, who they cannot go to for professional advice, and who are unable to help give them direction in setting priorities. "How can someone who has never done this job do my performance appraisal"?

Managers found this a source of frustration as well.

"The staff are of the belief, I believe, that I don't know what I'm talking about when it comes to the technology…they know better".
"In my particular department there is a feeling that I just don't know what I am doing"

Many participants spoke of poor communications in the districts and facilities, their frustration with managers that don't consult staff before making major changes, and how their opinions may be sought but they are never "listened to" or "followed through on". Others talked about the impact on morale of inconsistent district standards and policies and about a management that had no vision or strategic "direction" or was always operating "in crisis mode". Front line managers talked about their inability to plan because their work "is crisis management", because they are "not given the chance to plan anymore, you're always putting out a fire".

Several participants pointed out that when employees have to constantly operate in crisis mode people burn out quicker and "take that home too".

> "That business of going from crisis to crisis to crisis…when a person is exposed to that time and time and time again how much of that we start carrying ourselves".

Communications between districts was also raised as an issue in several discussion groups. Although they thought things were improving, participants in several group said we still have a long way to go to ensure a seamless integration of care for patients either going to larger centres or returning home.

Front line managers told us they find it extremely difficult to implement the collective agreements. Many are quite discouraged by having to spend a great deal of their work time trying to "interpret" or sort out contract issues, and interpret the changes to three different contracts. One participant said that having three separate unions to satisfy is a constant learning process.

> "We spend so much of our time back and forth…through district office, through union representatives…I'm sure a third of our job if not more seems to hinge on dealing with union issues and that's very frustrating...probably the most frustrating part of my job".
> "My frustration comes from I'm willing to give, give, give but the union contract is there and they won't give an inch, you know, I'm really flexible but they're not…and so you're bending over backwards all the time and nobody else is".

Front line managers also talked about how difficult it is to manage when they are "responsible but not accountable". They see the staffing problems and are frustrated because they have no control over the budget and the budget is insufficient to replace staff for holidays and illness. They said they "don't have the time or the authority to prevent the fire" and "it makes you wonder how they retain any of us".

By far, participants reported their biggest issue about workplace management is what has happened to orientation, training, and professional development since district formation and health reform. We heard about new employees that have no or only minimal orientation to new workplaces; that are writing their own job descriptions; that are partnered with already too-busy mentors to learn the ropes; or that are themselves training new staff. We heard about how employees are expected to use new technologies such as computer systems but training is insufficient; about in-services that are interrupted; and about districts where training is available locally but there is no one to replace you and people attend on their own time on their days off. We heard from managers that it is often difficult to decide who is the most important person to send to a training course.

In almost all the discussion groups, participants grieved the loss of their professional development budgets. Participants told us about annual professional development budgets of two hundred dollars *and less*—hardly enough money to cover travel to a course or conference within the province, much less enough money to cover registration or accommodations. And, they told us because their employers expect them to keep up with advances in their professions they often would split the costs of attending courses and conference (if they wanted to attend on their own time).

> "Credit to the district, they paid for the course but they did not pay for me to take it. I took it with two of the full-time staff, they got paid I didn't".

Participants also told us they felt no support (monetary and otherwise) from managers to formally upgrade their education, and when they did so at their own expense, they did not feel they were adequately reimbursed (compensated) for their investment.

How the external environment affects the workplace

Participants in many of the groups told us about how they believed the external environment affected the health workplace and impacted recruitment and retention. They talked about the rural nature of many health workplaces in our province, and they talked about the influence of the department of health, of their local communities, and of public perceptions of the system.

Many participants who spoke of the rural nature of their work talked about the amount of travel that engendered. They talked about "all the dead time spent in the car" and "phenomenal down time" and about only seeing four clients in a day because of the travel involved. Several participants who were the lone service provider in their districts talked about challenging work that offered them a great deal of independence. One participant reported they like the holistic approach that rural practice affords.

> "I really enjoy my profession. I find it very challenging…sometimes its frustrating but I think overall I have a lot of job satisfaction and really enjoy the small rural type hospitals…every place has its good points and its bad points…and I certainly enjoy a holistic approach with a smaller place. I think we're much more in touch".

In talking about the influence of the health department, some participants defended the government's wellness vision. Others talked about mistrust of the government and the frustration of working in a system with no support for implementing the vision and with no central leadership.

"They never had a detailed plan"
"Funding was supposed to follow the patient, but it doesn't"
"All you hear now is budget, oh we can't order this because it's the budget, we can't have that cause its over the budget…its all you hear"
"Volunteers are expected to pick up the slack".

Many participants expressed concern about a lack of money in the health system and money taken out of acute care and put into disease prevention and health promotion where results aren't apparent overnight, "they are robbing Peter to pay Paul". Others said it is hard to keep things in perspective in their workplaces when the "government is panicking".

Most groups talked about the impact of local community and public perceptions on recruitment efforts and satisfaction within the health workplace. They talked about public expectations with our health care system that are unrealistic "Canadians expect to be looked after from cradle to grave". They talked about their frustration with the negative picture of the system painted by the media and how those at the front-line take the flack from patients and their families about things over which they have no control: "I get told off once a week because of our waiting lists".

Addressing Challenges to Recruitment and Retention

Discussion group participants also shared with us their thoughts on how recruitment and retention challenges might be addressed. We asked them: *It is your job to recruit and retain the* front-*line staff in your district. Knowing all the issues we have discussed today, what would you do*? Their responses are listed in Appendix G; key items are discussed below.

Recruitment

Participants told us that to recruit health care professionals the health districts need a strategic recruitment plan so they can anticipate staffing needs in the future and plan for recruitment before positions are left vacant. Participants also felt quite strongly that all of the health districts have to work together on a plan for recruitment for Saskatchewan.

Specifically, discussion group participants told us, to attract new people to work in the health districts in Saskatchewan, health districts have to:

- Offer job security—permanent jobs that are full-time or positions with guaranteed hours;
- Address issues of pay equity—offer jobs with wages and benefits comparable with at least the other western Canadian provinces;
- Provide additional incentives, including:
    - Moving expenses
    - Temporary housing
    - Signing bonuses (contingent on recruits signing at least a two-year contract)
    - Annual salary increases;
- Demonstrate to new recruits there are opportunities for career development by guaranteeing sufficient money to attend, and paid time off for, professional development;
- Sell potential employees (and their spouses) on the job and on the community.

Participants also suggested it would facilitate recruitment efforts (and may enhance retention of new recruits) if districts could:

- Show potential employees we have healthy workplaces—with appropriate caseloads, clerical support, and coverage for people when they are sick or want holidays;
- Give providers access to state-of-the-art equipment and adequate budgets to stay up to date with technological changes in their fields;
- Explore opportunities to court potential professional recruits:
    - By advertising positions nationally, selling the district and the community
    - By advertising at recruitment fairs
    - By talking to students before their final program year.

Many of the discussion groups also suggested that in Saskatchewan we need a longer-term vision of recruitment to the health professions starting with:

- Reviewing and assessing current opportunities for education in the health professions;
- Enhancing the visibility of the health professions;
- Enhancing the image portrayed in the media of health professionals and the health system;
- Exploring opportunities to train health workers locally;
- Talking to high school students about careers in health care;

- Encouraging local people to choose health professions by offering them bursaries, loans, or even free-tuition, and by guaranteeing them employment when they graduate.

Retention and Job Satisfaction

Discussion group participants told us that if health districts are interested in employee retention and satisfaction they need to show their employees they are valued, they must treat them with respect; and they must treat them like professionals. To do this districts must:

- Involve front-line staff in planning and decision-making. Ask them on an on-going basis for their input and provide them with feedback when decisions are made.
- Create and support opportunities for professional development and growth for both front-line care providers and management. Provide incentives for staff to further their education. Guarantee adequate resources in the districts are available ($ and paid work time off) for staff to attend conferences, participate in training workshops, or upgrade their education.
- Recognize and support the work of those on the front-line. Acknowledge employees with a "pat on the back". Show them their work is appreciated, "you did well, you stuck it out".
- Address job security concerns. Acknowledge that some people want full-time work while others may want to job-share.
- Attend to employees workplace concerns about workload, work tasks, burn-out, and the effect workplace issues are having on patients.
- Ensure employees have channels through which they can safely and confidentially voice concerns and have them addressed without fear of reprisal;
- Offer new and existing staff benefits comparable with other professional groups outside of healthcare.
- Offer staff incentives and bonuses such as free parking, day-care, and work time-off to network with peers.

Summary

We asked front-line health providers and supervisors to identify current and future challenges in the recruitment and retention of needed health providers. The key challenges they identified were:

- Problems created by current workloads and expectations placed on all professional staff to do work that was not 'theirs';
- Issues about the physical work environment such as access to equipment;
- People issues in work environment including staff composition and organization, and opportunities for peer interaction;
- Their inability to access permanent work to ensure a secure stable job in health in this province; and
- The lack of support in our health districts for professional development.

These issues are all just the symptoms. Participants told us the real problem is that employees are not valued; they are not treated with respect; and they are not treated like professionals.

To address recruitment challenges, our discussion group participants said individual health districts needed a strategic recruitment plan that was a part of a provincial plan for recruitment for Saskatchewan. Specifically, discussion group participants told us, to attract new people to work in the health districts in Saskatchewan, health districts have to offer job security; address issues of pay equity; provide incentives such as moving expenses or signing bonuses; demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, and paid time off for, professional development; and sell potential employees (and their spouses) on the job and on the community.

To address issues of retention and job satisfaction, health districts need to foster 'organizational commitment' among their employees. Participants told us that districts can do this by involving front-line staff in planning and decision-making; by creating and supporting opportunities for professional development and growth; by showing those on the front-line they appreciate their hard work.

Participants also told us that districts have to address job security concerns and attend to employees' workplace concerns about workload, work tasks, burnout, and the effect workplace issues are having on patients.

Unions and Regulators

During the term of the research, Dr. Backman consulted with the following regulators, unions and professional associations:

- Canadian Union of Public Employees,
- Health Sciences Association,
- Registered Psychiatric Nurses Association of Saskatchewan,
- Saskatchewan Association of Healthcare Organisations,
- Saskatchewan Association of Licensed Practical Nurses,
- Saskatchewan College of Physical Therapists,
- Saskatchewan Medical Association,
- Saskatchewan Psychological Association,
- Saskatchewan Registered Nurses Association,
- Saskatchewan Union of Nurses,
- Service Employees International Union.

The information collected from unions, regulators and professional associations is somewhat more heterogeneous in nature than that gleaned from the discussion groups with front line providers and managers, and the semi-structured interviews with senior managers. In spite of the different messages received from regulators and unions, there were nonetheless some common themes and the meetings were invariably invaluable in helping the research team understand the complex issues concerning job retention, recruitment, satisfaction and skill mix.

Skill Mix and Redistribution of Work

Most of the groups interviewed indicated that their members were not utilized to the full extent of their scopes of competencies and that full use of their skills could result in better patient outcomes and savings to the health care system. One union executive noted that the problem of enhanced skill mix is that there is often a shortage of the occupation whose role is being expanded. For example, "ORT's[13] may be able to do some nursing functions, but where do we get the ORT's to do them?"

Different organizations had different ideas about the re-allocation of work between traditional occupational and professional categories. For example, SUN approaches the issue of LPN utilization in this way:

> LPNs have an appropriate role within the system and it depends on overall staffing numbers. The use of LPNs depends on what the local needs are and on such things as acuity, type of care, type of facility, types of conditions / illnesses, etc. What is key is the condition of the clients. Management seldom looks at replacing Special Care Aides with LPNs. They look at replacing RNs with LPNs. Thus, money is the driving force as opposed to client needs. Where work is performed by people of different categories, team functioning is important for work organization.

The Health Sciences Association believes that re-allocating the skill mix leads to a 'watering down' of best practices, that is, a 'generalist' approach is becoming too common. This approach is attractive to management because it opens the door to a variety of providers. This union noted that vacant positions are being lost and the unmet client need is being transferred to a less qualified person such as a physiotherapy aide or LPN. In fact, the union is not comfortable with the term skill mix, preferring to use "deprofessionalisation'. Deprofessionalisation leads to a loss of specialized services within the system and without them, we lose our specialized expertise which leads to lower wages for lower skills.

The Saskatchewan Psychological Association agreed that there is some overlap between the skills of psychologists and others. However, there is often a lack of information about what psychologists have to offer that is unique to the profession. For example, a MSW[14] can do a good job of counselling but there are other skills that only psychologists have. This would be especially true in such areas as health psychology (pain management or diagnostic learning or development problems), neuro-psychology, ABI[15], Fit for active Living programs, research based assessment and treatment skills.

The organization of work

Several unions identified program management as being problematic. The fundamental objection is that members of specific professional groups can find themselves being supervised by members of other professional groups who may not have an appreciation of the obligations, competencies and knowledge necessary for competent practice. These supervisors would have difficulty both supervising professional activity and assessing clinical skills. In addition, since many clinical management positions in program management go to RNs, upward mobility is restricted for members of other professions. Program management also leads to too many reporting relationships, according to some union officials, which often leads to micro-management. Other participants in that interview agreed, but said that sometimes the opposite was true and their members sometimes practised in isolation with too few managers.

---

[13] Operating Room Technicians

[14] Master's of Social Work

[15] Acquired Brain Injury

Several interviewees expressed the opinion that overall management skills within the system are poor and that most new managers have good clinical skills but no management training or qualifications.

Time management and case management skills have become essential for health providers, according to one union. Because work has been organized in a manner that limits the ability of providers to look after all clients adequately, they "make rationing decisions all of the time." This is exacerbated by a deterioration of supports in the system such as clerical & typing services, computers, receptionists, office space, storage & filing, and even such things as Dictaphones. Where these resources are available, they are applied inconsistently throughout organizations and, overall, are rarer than they used to be.

Perceptions Regarding Management

Most unions expressed mixed sentiments regarding management. While there was an appreciation for the enormous difficulty in managing health care, there was often a feeling that management was not motivated to treat the union as a partner in decision making. Many union representatives expressed the view that management was erroneous in believing that collective agreements are a barrier to accomplishing managerial objectives. Unions often commented that many managers do not understand the collective agreements.

For example, one union spokesperson believed that managers need to learn to utilize staff better. He wondered why a Special Care aide / home care aide could not be a 'floater.' The same person could pull shifts in two different work places.

Many unions believed that if management was truly motivated to create more permanent full time positions, they could.

Some unions were concerned about the lack of access front line providers have to management. For example, SUN pointed out that nursing leadership has been stripped out of the system. Directors of Nursing and Directors of Care are increasingly rare and many managers are not nurse managers. Nursing managers used to spend more time on the ward if necessary and would champion providers' requests for more resources. Front line Registered Nurses do not participate in management meetings and no longer have an 'advocate' within management. While SUN does not necessarily advocate a return to the system of head nurses, they wonder what will take its place that will allow front line providers a 'voice' to management.

SUN is by no means the only union to believe that management has cut itself off from the voices of the providers. For example, a CUPE official commented that Front line managers have disappeared, what managers are left are in meetings all the time, and there is no one to go to when something is wrong.

The strikes of 1999 have taken their toll as well and several unions feel that their relationships with management and SAHO is at an all time low. SUN reports that its membership is still angry and has not seen some of the changes they feel they fought for in the strike. One union official said, "It feels like SAHO and the Government are at battle with our members. We have to fight for every little thing. It will be worse now with the [2000-2001] provincial budget, especially in rural areas." There is also a real fear that coming change will lead to layoffs. A SUN official commented that some nurses may not be able to re-locate, so there may very well be unemployed nurses in Saskatchewan before too long. Several other unions agree that layoffs are a real possibility.

More democratic workplaces were important to several unions. To SUN, this meant that registered nurses should have the clinical autonomy they need and they should have management's support of that. "Can you imagine," muses SUN's Executive Director, "Professional engineers being ordered to sign engineering plans that were dangerous?"

Perceptions Regarding Government

Many questioned whether the government was either motivated, or in a position to create real change in the workplace. As one Association Executive Director said, "You can't re-engineer the workplace on the cheap." Many of the union representatives felt that the Department of Health is out of touch with what is happening on the front lines. One Union Executive Director noted that there has been a retention problem with District Support Branch consultants. He believed that the Department is prone to issuing edicts that don't translate well into policy or practice and that the Districts tend to ignore Department policy and documents. He also felt that the Department could be, "Penny wise and pound foolish. They won't spend $10.00 to fix a problem but will spend $2.00 on a solution that won't work."

Perceptions Regarding Health Reform

Health reform is linked to employee morale and retention issues, according to many of the regulators and unions we interviewed. Many of these organizations called attention to systemic change and re-organization's effects on the long term career satisfaction of health providers. Much of the dissatisfaction in the workplace in the 2000s will have had its origins in the reforms of the 1990s.

Some union officials stated that the government has confused health reform with cost reduction. The perception of one Executive Director was that, "the government had lots of money for bureaucracy while people were being laid off. And as facilities were being closed, local boards were spending money on towels, linoleum flooring, linens, renovations, etc., all with local contractors." He went on to explain that this sort of activity set the tone for the bitterness of the union-management relationship that followed.

One union Executive Director said that, although everyone knew that health reform was coming in the early 1990s, there was an expectation that the new government would deal fairly with health workers after a long period of real wage deterioration. He insists that the current government "stabbed the unions in the back. Union members remember the Divine era fondly. They weren't well paid, but they were appreciated." He felt, however, that the government did not truly consult them. "Their attitude was, 'Our minds are made up; Don't confuse us with facts.' There was one-way communication of de facto policy decisions." Although the, "Government kept denying that there was a plan to reduce the cost of health care by laying off workers… I am convinced there was such a policy and it resulted in poorer health services due to fewer workers." Another Executive Director commented that morale disappeared in 1992 and was replaced with, "very little concern for the people who give the care."

Most union leaders believe that there was not well thought out labour re-adjustment strategy. Said one, "Districts were told to transition these workers, but the government had no money to build the bridge, so the districts had to teach them to leap. Health Reform took workers out of the institutional side and said their work would be done through home care, but home care does not have the supports (including equipment) to do the same jobs. There are many things that cannot be done in the home. Furthermore, outside of Saskatoon, Regina and P.A. there was no home care infrastructure which could immediately step in… Government saw home care as a cheap cousin and by keeping clients at home, deprived them of their ability to express themselves collectively. Now that home care workers are achieving wage parity with other health care workers, government has stopped lauding the praises of home care quite so much. The whole wellness model can be summed up as substituting needed sickness care with some hand holding, nutritional advice and little else. And worst of all, the reform process taught workers that they were expendable." This Executive Director went on to explain that before health reform, layoffs were extremely rare, but soon became very frequent. Some of his members have been laid off eight times since 1992. Although his union, and others, urged government to slow down, they wouldn't, so no one was prepared or willing to deal with the layoff issues. Another union Executive Director characterized health reform as, "'Speed up' and heavier workloads."

Many unions commented on the state of feeling after the 1999 collective bargaining and strikes. One union leader commented that members feel powerless in the face of the government's response to collective bargaining last year. "Members see bargaining as the only tool they have to resolve problems and that is regretful. Members want the collective agreement to be a 'magic pill' to solve their problems and this is troubling to all. It means a centralized solution to local problems… Collective bargaining is often linked to 'clinical militancy'[16] rather than a means to better wages, hours and working conditions."

Future health reform

Many interviewees believe that systemic change will continue. Many of the union officials predicted layoffs as the result of more closures and budget constraints. One union executive asked. "If we re-draw the district map, what labour readjustment goes with it? We just got over Dorsey and can live with the results. But we don't want to go through it again." Another asked, "Do you know how you can remove $12 million from the Regina Health Board's budget without layoffs?" Even if layoffs are primarily among support personnel, it will lead to the inability of providers to do their jobs. "It means nurses will do more ward clerking, more portering, etc. It means piles of linen lying around because there is no one to deal with it," said a nursing union leader.

One union spokesperson noted that health districts have to have their 2000 health plans in by May 15th, followed by a review of the system. "But the fact is, the [provincial] budget will be the prime determinant of what the system will look like and the budget provides very limited room for manoeuvrability."

One union noted that constant systemic and organizational change has led both to poor satisfaction and declining quality of care in the system at a time when populations are becoming more needy. Unless faith in the health care system can be re-instilled, said a representative, people won't want to go into health care professions.

---

[16] i.e. a tool to create better clinical outcomes

Workload Issues

Most of the unions listed workload and remuneration as their top two concerns surrounding job satisfaction, recruitment and retention. Regulators were concerned about workload as well, especially in terms of its impact on the quality of care, a concern that was shared by unions. One union leader said that providers often go home exhausted, that programs are often added without increasing staff numbers and that providers often stay past quitting time without applying for overtime out of professional commitment, all for poor pay.

Nurses workload issues are different in long term care, acute care and community based practice. In long term care, work overload is associated with assessments and medication administration. In Regina, reports a SUN official, 3,000 immunizations were given in 1992. In 1999, the same number of RNs administered 30,000 immunizations. Community mental health nurses are overloaded as well.

Some unions reported that workload measurement tools are either ignored or no longer used because even if they indicated inadequate staffing, no steps were ever taken to remedy the deficit. A SUN official noted that there are no required standards for nurse:patient ratios. And those standards that are available are neither required nor followed. For example, there is a standard that indicates a 1:1 ratio for ventilated patients, but this standard does not apply to chronically ventilated patients. According to SUN, there is a Regina long term care unit that has between three to five ventilated residents out of a total of 42. One RN is in charge of 22 of these patients including all those on ventilators. Another example offered by SUN is the Health Canada standard of one nurse for each patient for dialysis yet satellite dialysis clinics are below this standard and continue to deteriorate.

A common theme concerned the lack or reduction of supports for providers. One interviewee observed, "Ask the Diagnostic Imaging people about the new MRIs. They have no new resources, no additional people and are expected to man an additional MRI in Saskatoon. In addition, the health board is cutting their budget, even though this is supposed to be an area of expansion." Unions and regulators were equally distraught at the number of support personnel who had been cut from the system. These ranged from housekeepers and ward clerks to receptionists and typists. In addition, front line managers have been eliminated so providers now find themselves doing work that managers used to do.

The loss of front line managers is a theme that came up again and again. SUN noted that nursing leadership had been stripped out of the system. Many managers of nurses are not RNs themselves. Especially, noted SUN, head nurses are gone. The head nurse used to spend more time on the ward if necessary and go to bat to management to demand resources. While SUN is not advocating a return to head nurses, it wonders what will take its place. Front line nurses don't participate in management meetings so there is no input from the vanguard. Another union noted that administrative duties are devolving to the front line worker without compensation as front line managers disappear from the system. "Management needs to have a greater front line presence and to listen more closely. And middle management needs to be empowered to make decisions."

The changing nature of nursing work was raised as an issue. SUN officials suggested that the biggest difference between entry level degree and diploma RNs is how they think, not what they know. RNs need to think critically. This is needed as conditions continue to change in acute, long term and home care. Nurses will need to deal with increasing numbers of residents / clients/ patients and need to think clinically about them all. There is often only 1 RN for 80 residents in LTC so SUN believes that team leadership and critical thinking skills will become paramount.

Casualization of the Work Force

Most unions did not see casualization as being a huge issue for their members, at least while there were labour shortages. This does not mean, however that they had no concerns. One Executive Director did observe, "Casualization is an effort to have a more flexible work force and to avoid having to 'lay someone off'. Instead, you simply don't call them in." Another noted that many home care providers have more than one job and that RNs and LPNs often have a permanent part time position and have to work casual as well to earn a living. One Union leader noted that casual labour is not a good method to enhance job satisfaction. "We need to re-design the workforce so that there is less reliance on casual people. We need to look at staffing levels differently than we have historically. You will never recruit a new nurse to a casual position with a $40,000 student debt. And you need to think differently about rural areas versus urban areas. Rural women don't graduate from high school, go away to nursing school, and then return home to marry the farmer and work casually anymore."

The Saskatchewan Union of Nurses recognizes that its members have different needs at different points in their career ladders. Some members may genuinely want to work casually at some point and these should be given that opportunity. Right now, however, health providers often move to a casual basis as a means to avoid the over work, call-back and an effort to exert some control over their working life. This is driven by the shortage of nurses.

Recruitment and retention strategies

Some respondents felt that there is no provincial recruitment or retention strategy. Others opined that a provincial strategy would be cumbersome and difficult to co-ordinate while what is really needed are local solutions to what are largely local retention problems

One union president emphasized that recruitment was not the primary problem in health care workforce management — retention is. "There is no point doing recruitment if you can't keep people in the system." The same person noted that some districts do exit interviews but asked what they do with them. One union leader noted that the key to retention is to make good workplaces. "If people are happy in their job, they will bid in and out [of positions] less frequently. This will lead to a more stable workforce. A more satisfied workforce will lead to word of mouth recruitment"

The Saskatchewan Union of Nurses is enthusiastic about the promise of magnet hospitals which are known as good places to work, have success at recruiting and retaining nurses and which some literature shows, have better clinical outcomes as well. SUN also feels that it is important to achieve some success in the short term. As its President, Rosalie Longmoore said, "If we manage to do something positive at this time, it may raise morale. We need to be innovative and try new things... If they don't work, we should abandon them and try something else." As an example, SUN mentions a possible pilot project they have been discussing with the Department of Health and 4 district CEOs for an experimental unit that would try various strategies to improve job satisfaction. For example, explained Beverley Crossman, SUN's Executive Director, "we could adjust bed:RN ratios, change the numbers of front line managers or the amount of time those managers actually spend in the ward, adjust work schedules, change physician relationships, or whatever is needed to meet the needs of that particular unit and its patients, residents and clients."

Some union leaders and regulators suggested bursary programs to encourage people to return after their post-secondary education. Said one, "Why don't we pay local people to become RNs and come back to the community?" She noted that selection of appropriate candidates with roots in the community is key to getting compliance.

Another commonly suggested strategy involves finding jobs for spouses of health care providers. Among suggestions were establishing partnerships with other local employers or recruiting in Atlantic Canada and other areas with high unemployment.

Wages were mentioned several times as recruitment and retention tools. It was often pointed out that wages are not competitive with those in other provinces and the mobile nature of professionals can lead them to migrate towards better paying jurisdictions. Other areas where some interviewees felt other jurisdictions were more competitive included hours and shift assignments.

Opportunities for continuing education were identified by several unions as being key retention factors. Furthermore, what funding is available for continuing education is used as a tool by management to retain control. One union reported that discretionary funding for professional education conferences was allocated in an inconsistent and non-transparent manner. One regulator, the Saskatchewan Psychological Association, noted that many of its members were PhD prepared and thus want to be part of the academic community. Not only does this make opportunities to attend academic conferences essential, but it would be helpful if health districts could facilitate an association with the Universities. This is easily done in Saskatoon and Regina but funding for travel would be important elsewhere.

A representative of one of the nursing regulators suggested that recruitment out of high school into entry level jobs is a solution. "We can nurture them into nursing with bursaries and promote the organization as a 'family'". The same representative suggested that some nurses quit as they age because they can't "hack it" any more. A solution may be 'Accommodation Units' where more nurses towards the end of their careers could work 4 hour shifts with clients who will benefit from their experience.

One union executive committee suggested the following list of strategies for recruitment:

- Make it easy to come to Saskatchewan by offering an opportunity to try employment here and have expenses paid to move back after a trial period
- Guaranteed continuing education
- Up front commitments regarding clerical support and workload
- Having response mechanism in place if promises are not kept.
- Addressing the farm crisis and encouraging a favourable economic climate
- A publicity campaign on why Saskatchewan is a good place to live
- Offering a specific workplace or program. E.g. always orthopaedics or always rehab.

- Encouraging students to go into health care through such things as job shadowing and work placements.

Other Issues

Education of Registered Nurses

Some of the interviewed unions and regulators expressed views regarding the NEPS program for the education of RPNs and RNs.

Among the comments were:

- The focus of NEPS is largely in the community, but most RNs will continue to work in institutional settings and may not be prepared adequately.
    - There are no mentors available in the institutional workplace with the time to provide the requisite skills to new graduates.
- NEPS will result in younger graduates, who will want to work full time and have longer careers than the average 32 year old students under the old system

Senior Management Teams

The themes talked about by senior management teams can be divided according to the following taxonomy:

- Workload Measurements
- Staffing
- Workload
- Recruitment and Retention
- Staff Mix and Skill Mix
- Collective Agreements and Management Rights
- Structuring Work
- Attitudes towards the Health Care System Environment

Workload Measurements

Senior management teams expressed a great deal of dissatisfaction with the tools available to them to determine appropriate staff mixes. Specifically, many expressed a desire for workload measurement tools. Several issues were identified regarding these benchmarks.

- There was a feeling that for workload benchmarks to work, physicians would have to do much of the work and they were over-burdened as it is. It would be difficult to get physician compliance and without it, the necessary documentation chain could not be maintained.

- Some felt that workload benchmarks were futile if the Districts did not have the resources to comply with needed staffing levels. One senior manager from a larger district reported, "NISS and Medicus were useful, but your couldn't get funding to bring in more staff if the tools indicated you needed to. So we threw out the tools. Now, staffing decision making is anecdotal at best."
- Most of the existing workload measurement tools are out of date and aren't compatible with regionalized health care systems.
- Many existing workload benchmarks are inflated. Some managers attributed this to their having been developed originally by professional associations.

Staffing

There was some dissonance among senior managers as to the severity of the shortages of various categories of providers. Most managers reported difficulty recruiting nurses, physical and occupational therapists, speech language pathologists and psychologists. The area of contention revolved around whether or not such shortages, and especially the nursing shortage, was to be long term and how acute these shortages will ultimately become. Some managers felt that a crisis of major proportions is looming. Other managers felt that shortages were not so acute that they could not be addressed through innovative skill mix strategies. As one CEO reported, "We don't have a shortage of nurses. We have a problem with the way we utilize them." This CEO also noted that other industrial sectors were experiencing equal or worse shortages: "[We]... have a five per cent vacancy rate. Compare that to other industries that are happy with a 10 per cent vacancy rate."

An area of frustration for management is their dependence on the casual labour pool, especially in rural areas. There were several explanations for this. Using the example of a registered nurse in a small rural hospital, there may be one RN on duty each night shift. Managers estimate that each such shift actually requires between 1.4 and 1.6 FTEs due to vacations, family leave, sick leave, etc. and there are 7 such shifts to be covered each week. Managers insist that there is often no way to staff these shifts without the use of casuals. Float positions often prove unpopular and difficult to fill. One health district established float positions in an acute care setting and found that sick time and turnover were greater than in other positions.

One difficulty in terms of staffing is the increasing internal mobility of the workforce, especially amongst LPNs and RNs. Many managers reported a flurry of bidding in and out of positions. The largest districts have difficulty measuring their vacancy rates because many vacancies are the result of employees bidding for different positions within the organization. Float positions seem to be the most likely positions to be bid out of. Managers reported that they are often viewed as an 'in' to the organization and temporary at best. Positions in greatest demand are community health nursing positions and other positions which allow their incumbents to exercise some control over their work volumes and schedules.

Minimum Staffing

Part of the problem is the dependence upon minimum staffing levels. "We use minimum staffing levels so we **have** to replace people when they are sick or on leave. In the old days we had extra staff as a matter of course... Minimum staffing doesn't work," reported one CEO. The effect of minimum staffing on retention recruitment, job satisfaction and patient / client outcomes was often cited as a crucial human resources issue. One CEO remarked that a surplus of even 10 per cent over minimal staffing would go a long way to alleviating the need for casualization.

There is some evidence in services management literature to suggest that operating at or near to capacity will lead to dissatisfaction of the workforce and a deterioration of quality (Rigby and Backman, 1999).

Workload

One of the most persistent inconsistencies between the perceptions provided by frontline providers and senior managers revolved around the issue of workload. Certainly the discussion groups held with providers and front line managers revealed the perception that workloads were approaching untenable levels. Senior managers, however, reported a somewhat different assessment. They felt that front line providers worked hard but that, in spite of occasional stressful shifts, the workload was not unduly arduous. Most managers conceded that workloads had increased in the last 15 years. One CEO said, "There is no question nurses work hard, but it all comes down to how much one can expect from an RN. Of course, we **are** paying them $25 an hour... There are times when they are extremely busy, but, especially in rural health care, it varies. Some shifts, such as night shifts, are pretty easy. We have an RN who learned to speak Spanish in her spare time on night shift."

Senior managers, however, were not insensitive to providers. There was a consensus that the more urban a health care facility, the harder the staff had to work. In addition, senior managers were sympathetic to the notion that providers might see their workload as being unmanageable, whether or not it was actually true. One senior manager reported that some facilities in her district used to have a 60 per cent occupancy rate and were now consistently full. Another manager from the same district reported that many providers moved from acute care to long term care which was, physically, more demanding. Many providers are now expected to work in both long term and acute care on the same shift due to the advent of integrated facilities. This innovation leads to more cases and more variety of work. There was a general acknowledgement that acuity in facilities is up and that staffing levels had not increased proportionately. One manager said, "We are expecting more from our front line workers which leads to burn out. In addition, there was acknowledgement that provider supports had been cut back severely. "We try to keep as many hands at the bedside as possible so it's the support people who go," said one manager, talking about the demise of such occupational categories as ward clerks and receptionists. Another senior manager expressed the conflict between service provision and workload this way: "Our district has three goals – A healthy community, a healthy organization and a healthy workforce. You can't have the first in the absence of the last, but everyone needs to realize that the first is our raison d'être."

Managers widely recognized that staffing shortages are having a great effect on workload in the guise of increased call back and the inability to take vacations and leaves when desired. Some managers reported that they are presently denying all leave in rural facilities and suggested that they are considering closing facilities for several weeks or months over the summer to allow people to take vacations. Many reported that the supply of rural nurses is so finite that the loss of even one due to retirement, sickness or separation could result in the facility becoming non-viable.

Recruitment and Retention

Senior management teams recognize that the nature of health care provision is changing and are aware of dissatisfaction among providers. They report feeling torn between an understanding of the concerns of providers and the need to continue to provide high levels of services despite the reality of scarce resources. Typical of this awareness is the report of a senior nursing manager. "Nurses don't do the rewarding stuff anymore. The pill pushing is not as rewarding." She explained that the bedside care was always the most satisfying part of the job.

Managers recognized that existing employees have different needs which cause them to bid in and out of jobs. For some, the desire to move to a permanent full time position rests in the long term security offered by such a position. It is not unusual for an employee to move into such a job and then immediately apply for job sharing. Clearly it is the flexibility of being able to move back to full time at a later date that is attractive. Other employees prefer part time or casual positions. These preferences often revolve around personal or family situations. As one senior manager said, "Not all employees **want** to work full time. People getting permanent full time want to job share. What attracts them is the security of the position. Once they 'own' it, they have flexibility."

Some management teams felt that a provincial strategy for recruitment and retention is needed. One stated, "Recruitment is a provincial issue and we need provincial strategies, leadership and solutions rather than 33 different efforts." Others felt that recruitment was a local issue. One stated that, "Personal networking is the single most important recruitment / retention strategy." Several related anecdotes of existing staff people recruiting new employees at conferences or in other ways. Even those who supported a provincial strategy cited competition between health districts as being a fundamental barrier to any successful centralized effort.

The need to work shifts and weekends is recognized by managers as a retention issue, particularly as full time shift workers approach the later part of their careers. There was much support for the notion of the "weekend worker" that was recently entrenched in the Ontario Nurses Association collective agreement.

Restructuring has resulted in fewer front line managers and the physical centralization of management in general. This has interfered with the ability of managers to manage. One CEO complained, "Morale started to slide with decentralization. Your boss is not there anymore. Discipline, pats on the back, mentoring, etc. are from someone else who is remote. This is no workplace, especially for new employees."

Some rural managers noted that even when it is possible to recruit some professionals such as physical therapists, those willing to locate to rural areas tend to be less experienced and younger. The cities attract those with more experience. While the managers were confident that these new graduates have the entry level competencies needed for the profession, they were concerned that taking a job where there is little peer support or interaction can be intimidating for some.

There was general agreement that the older 'tried and true' strategies no longer work as well as they once did. One of the most commonly cited such strategy was to hire nurses and other health professionals who were married to RCMP members, teachers and others who moved to town to take jobs. One manager commented, "The RCMP are often married to nurses but they don't transfer as much as they used to and they have closed a lot of detachments."

Another barrier to retention of health providers is the lack of proper information systems. Regina and Saskatoon, for example have some difficulty knowing precisely what their turnover rates are because of frequent bidding in and out of various positions. It is difficult to distinguish new hires from transfers. A Vice President of a large district identified the lack of a provincial Human Resources Information System as a liability and also pointed out that pre-district records are either missing or incompatible with present technologies. As a result, it is difficult to know which pre-1992 employees are still with the district, information which is important for retention planning.

Several senior management teams discussed what would happen if a dire shortage of registered nurses were to occur and how they would manage the crisis. Among the solutions were:

- Take RNs out of rural Long term care facilities and close the Emergency services in those facilities
- Reduce the number of individual AC centres.
- Eliminate RNs coverage during evenings and nights where possible
- Train as many aides as possible (Aides are scarce too)

Competition

One of the biggest barriers to recruitment and retention identified by senior management teams was competition. Alberta was often cast as an adversary due to its tax structure, better wages, and housing prices. and thriving private sector physical therapy and pharmacy practices. Manitoba and the USA were also cited as major competitors for existing and potential employees. "Saskatchewan has a poor reputation for things like taxation levels," reported one manager.

The private sector was similarly cast as competition. One manager noted that the local Wal-Mart store paid pharmacists $7 more per hour than the health district could. The private sector was also blamed for difficulties hiring physical therapists and diagnostic imaging technicians. One manager explained how easy it would be for a private practice to set up locally and out pay the health district in the short term. Unable to attract therapists or radiology or ultrasound technicians, the district would have to contract out these services. Once it was dependent on the service, the private company could diminish wages, benefits and working conditions.

Competition also manifests itself in the urban-rural split. Small districts compete with larger cities for all categories of providers and also compete, reminded one manager, "with Dallas, Miami and Toronto." "And American recruiters are **very** slick," contributed a colleague. Rural managers often stated that providers simply will not move to rural areas. One rural town has been looking unsuccessfully for 2 primary care nurses and is unable to fill the positions. Rural managers also recognized that they are at a disadvantage in terms of their ability to provide incentives such as signing or retention bonuses. "Health Districts," explained a team, citing emerging bidding wars, "are our own worst enemy because we compete with each other."

Strategies

Managers suggested several strategies for recruitment and retention. They included:

- Increase the labour supply through education, immigration or other means.
- Incentives (signing bonuses, etc.)
  - Several suggested that recruitment incentives would have to be retroactive in order to be equitable. This is because recently hired employees might feel unfairly treated
- Full time jobs for new grads
  - The greatest obstacle to this strategy was identified as being the terms of existing collective agreements
- Increase the number of seats in nursing and physical therapy programs. Encourage more people to take the combined technician courses. Start training occupational therapists and speech language pathologists in Saskatchewan.
- Incentives to get senior nurses to give up FT positions or retire early
- Bursaries for students of nursing, occupational and physical therapies, speech language pathology and other scarce occupational categories.
  - Different managers recommended different criteria for these bursaries although all entailed a commitment to practice in either rural or northern areas or simply in Saskatchewan for a set period of time after graduation.
- Provision of clinical opportunities for students to do placements.

Rural Challenges

One of the most significant barriers to recruitment was the overall lack of attractiveness inherent in Saskatchewan itself. "Canadians don't want to live in Saskatchewan and we don't market Saskatchewan at all as a good place to live," observed one manager. Another noted that the geography of rural areas is often a disincentive to recruitment, especially since small facilities and sparse populations lead to the need for casual workers, the lack of full time opportunities and the inability to guarantee enough hours. The lack of amenities such as malls and theatres were cited although some managers report emphasizing that their communities are only a short drive from Regina or Saskatoon. Distance from peers and isolated practice were factors for therapists and some other provider occupations. Some managers noted that local people are no longer returning to their communities after they complete post secondary education and that even if they did, collective agreements would not allow districts to offer them full time work. The most common barrier related to rural Saskatchewan was the difficulty of providing jobs for spouses. One manager observed, "You are not recruiting a nurse, you are recruiting a family. The spouse needs a career fit too." At least one district reported developing a working relationship with the local school board to do joint recruiting.

One manager suggested it might be easier to pay consumers to travel to the service rather than paying the itinerant employee to travel to small towns. Several managers spoke at length of the difficulty to maintain the operations of small rural facilities where every nurse living locally is either already working in the facility or refuses to. As one manager put it, "If one of your 2 RNs quits, you are in real trouble!" When the researcher asked some of the teams if the system were in danger of facility closures because adequate staffing could not be achieved, not one manager denied it.

Recruitment and retention of Management

Many managers stressed that the recruitment of management personnel is amongst the biggest of their challenges. Part of the problem is supply. "There are not many managers who are trained to have a vision of what an integrated health care system means," explains one CEO. Salaries are not competitive with other, more stable industries or with health care in other provinces. One Vice President of Finance observed, "If you can't compete outside Saskatchewan, you end up cannibalizing health care in Saskatchewan. You steal from other districts. Such raiding is frequent." A CEO stated, "Management quality is poor due to competition elsewhere. When you can't get people to come to Saskatchewan — to your organization — you get what you pay for… Saskatchewan is seen as the "gateway out of the North". People come here and then immediately look for a position somewhere else."

Front line managers are difficult to recruit because the pay differential does not even begin to approach the additional responsibilities inherent in the job. One subject stated, "The rewards simply aren't worth it!" Another simply stated, "The workload is ridiculous." Balancing Work and Family initiatives have taken their toll on managers whose workloads have increased geometrically. One CEO said, "Middle management is the worst job in health care today. They are under-appreciated and can exercise no control." The only incentive some could think of for taking a front line managerial position was to get out of shift work. In addition, there are much fewer front line management positions due to the cut backs since restructuring. This has exacerbated the workloads.

An additional problem retaining front line managers comes of the inability to offer them managerial training. Many of these managers have strong clinical backgrounds and skills, but virtually no preparation to assume management functions.

Many managers reported that talk of further restructuring is causing people to leave health care for other managerial positions. Lateral transfers are unattractive because managers do not retain their seniority within the province as in scope people do and job security is minimal given the risk of re-structuring in a district they have recently moved to. One manager commented that, "the Brain Drain of managers is an issue. Nurse managers are hard to find and CFO's are particularly rare. Since 1992 there have been no funded increases for out of scope people. The Hayes recommendations are difficult to meet." Another mentioned that getting a manager with a Masters degree in nursing or health services management was next to impossible.

Managers were upset with the perception that management is bloated and overpaid. Many cited examples of public and private sector comparisons which indicated the contrary to be true. "The reality", stated one Vice President, "is that managers are being asked to manage during an incredibly turbulent time without decent supports." Management teams consistently expressed the belief that they are undervalued by government and their boards and that the number of managers within the system has been cut too much. One CEO reported that, "Managers feel their voices are not being heard. Their views on the system are disregarded. Its like the government are waiting for them to fail."

Time and time again, we heard about management compression, which is the result of a lack of increases in funding for management positions and increases in collective agreements. The result is that the income gap between management and in scope personnel is minimal. The biggest impact is on front line managers who often earn about the same, or even less than their in-scope reports. One HR director noted that, "a general duty nurse can make $60,000 with overtime. Why would she want to be a nurse manager?"

One CEO protested that poor CEO salaries lead to compression right down the management structure. He suggested that we should consider, "Perhaps parity with the crowns would be appropriate or even parity with Manitoba? Management salaries at all levels are not commensurate with responsibilities. Sometimes they are too high, sometimes too low. We need a rationalized structure for management salaries based on market factors and the 'grid' used by SAHO does not accomplish that." He added, "Recruitment and retention must be a top down approach. First, you must recruit and retain good management. To get them, pay them. "

Continuing education and On the Job Training

On the job training was a big issue for senior managers, especially as it applied to aides. The availability of SIAST special care and home care aide programs varies tremendously in terms of availability and cost. Many districts provide resources so that the courses can be offered on site or locally. Several are co-operating with aboriginal educational bodies to offer the classes. Some expressed frustration about the present curriculum and others did not see the value of SIAST's involvement. SIAST tuition rates are also rather expensive and often exceed the cost of University tuitions.

Ironically, unions had their own concerns about the SIAST Aide programs. One union official suggested that the "SIAST aide course is a 'Mickey Mouse' course and the necessary skills can be learned on the job. There is no reason to have to move to a SIAST town to learn this stuff. Job mobility is a problem with the course. The certificate is not needed in acute care, but it is in long term or home care. Special care aides and home care aides are not interchangeable either." That union would prefer an on the job course terminating in a certificate

Continuing education opportunities were widely seen as effective retention strategies and many managers bemoaned their inability to devote more resources to providing them. Many were proud of their achievements. One team reported providing support for new physiotherapists who wished to write the national exams. A CEO, explaining that opportunities for education lead to a greater feeling of appreciation, higher morale and greater confidence, proudly disclosed that his district spends between one to two per cent of the payroll on continuing education. He felt that a special provincial earmarking of funds for continuing education would be a helpful part of a provincial strategy and that it might be useful to distribute the funds according to the population-needs based funding formula.

Staff Mix and Skill Mix

There was wide consensus that one of the challenges management would face in the future would be re-designing work to take advantage of appropriate staff and skill mixes. One manager stated that first, "we need to determine what skills are needed to get a job done and then decide who has those skills and the time." "The goal", said another, "is how to get the human resources we need, when we need them and where we need them." A third contributed, "We need to determine the services we should offer. Then the skill mix we need. Finally, who ought to provide those skills." It was recognized that barriers to this include turf protection and traditional stove-piping. One CEO remarked, "If we all have a vision of a sustainable health care system, we must let go of our own interests and work for the greater good."

One area of dissonance between what senior managers and front line providers told us relates to the expansion of the roles of those providers. Providers invariably saw any expansion of their role as preventing them from doing the jobs they are meant to do. Several districts are proud of the way they are expanding the roles of front line providers. For example, one district now has acute care nurses fielding phone calls from home care clients. This district is considering expanding the role to include answering calls to long term care homes as well. One district is wondering why different RNs are needed on both sides of an integrated facility. Another is having Primary Care Nurses doing some community health nursing functions, noting that having all RNs represented by the same union has facilitated this sort of role expansion. Several openly admit that the motivation for re-thinking work compliments and skill mix derives from existent or impending shortages. They insist the alternative is to continue to ask for a larger commitment from the existing work force. One manager explained that an unattractive but nonetheless necessary alternative may be to decline such things as job sharing to employees who may prefer to work less than full time hours.

A vice president from a large district observed that many strategies for improving skill mix involve using lesser skilled individuals to do tasks traditionally done by more qualified people.[17] He went on to observe that RNs are often not used to the full extent of their scope of practice. They are expected to spend a lot of time undertaking a lot of mundane activities that used to be performed better by support persons such as housekeepers and ward clerks. Tradition has prevented us from using RNs for more challenging activities of which they are fully capable.

One district CEO felt that skill mix and staffing levels should be approached from a systemic viewpoint. He observed that demographic changes such as an ageing population and declining tax base make some difficult decisions inevitable. He suggested the Department of Health determine which services are to be offered in each centre as the starting point for determining how many people would be needed, where, and with what sets of skills.

Several strategies were suggested for adjusting staffing and skill mix to accommodate possible shortages of human and other resources. They included itinerant tech services, increased use of telemedicine and increased competition for those staff that are in the job market (especially outside of Saskatchewan), sign up bonuses, increased use of pharmacists and LPNs, increased non-nursing duties performed by RNs, job redesign to increase direct patient care by nurses, and increased resources for ward clerks and other support personnel. Another said, "We'd like to hire more ward clerks to support the RNs' work, but we don't have the money, so we don't." One CEO wondered if the will to change is really there, amongst both managers and health providers. Another manager speculated that both management and unions are addicted to past practice which focuses on professional designations and who traditionally performed a function rather than on the required skill sets for performing a given job.

Staffing and skill mix issues are by no means restricted to the nursing occupations. Many managers discussed the issues involved in using therapy assistants and aides as an adjunct to physical therapists, possible uses of emergency medical technicians in acute care and other settings, alternative uses of combined technicians, and the common and unique skill sets of psychologists, social workers, and other mental health care providers.

---

[17] This resonates with the comment by a union official that we often hear of LPNs taking over RN functions, but seldom of LPNs taking over Aide functions where they may be better qualified.

Licensed Practical Nurses

For the most part LPNs are used without consistency from health district to health district. For example, we found districts where LPNs were used in only acute care settings, others where they were used in only long term care settings, other where they were used in all settings, including home care. Policies as to LPNs scope of practice sometimes varied from facility to facility within the same health district and even from ward to ward within one facility. In many locations, LPNs were not allowed to do such things as medication administration or catheterizations, even though they had been trained and qualified to do so. In at least one district that had integrated facilities, LPNs could do catheterizations and 'meds' on the long term care side, but not on the acute care side. Often policies regarding the use of LPNs in affiliates are in variance with practice in district owned programs.

Some managers noted that it was sometimes difficult to know which LPNs had which levels of competency. Others said that their districts had devoted resources to upgrading all LPNs to a minimum set of competencies so this problem would be overcome. Another suggested a "brownie badge" system would overcome any uncertainty.

Many managers reported a willingness to investigate the full use of the LPNs scope of competencies. Their experiences during the 1999 SUN strike caused them to be impressed with the abilities of LPNs. Although some reported rampant turf protection between the various categories of nurses, other reported good team environments. One observed that most nursing managers were either RNs or RPNs and were biased against the use of LPNs.

One manager observed that LPNs and other providers would become an important part of the team, and that this would create different needs for RNs. "Nursing education needs to emphasize delegation and skill mix use in teams. RNs need to see themselves as team managers who delegate nursing functions. LPNs need to delegate to aides."

Several districts are converting from RNs to LPNs in long term care (for at least some shifts) and using LPNs to replace RN's who are sick or on leave.

A common observation was that the use of LPNs as a 'substitute' for RNs or RPNs was not a panacea, if only for the reason that there is hardly a surplus of LPNs in the job market either. Several managers criticized the NEPS program for making it more difficult to 'bridge' LPNs to become RNs[18] and some added that having LPNs represented by a different union than the RNs and RPNs does not contribute to a flexible workplace. Several managers suggested that some sort of guaranteed job security to RNs might overcome a lot of their resistance to the use of LPNs.

Collective Agreements and Management Rights

When asked the question, "What are the major barriers to recruitment in Saskatchewan?", most senior management teams immediately identified the collective agreements. Seniority clauses were the major source of frustration. Attractive full time positions tend to be bid into by existing employees but managers consistently reported that new graduates and out of province applicants were interested only in full time positions. Most collective agreements require vacancies to be offered, in order, locally, district wide, provincially and then elsewhere. One manager said, "The biggest recruitment barrier is the inability to offer meaningful employment to new hires." Another manager said, "We have full time permanent positions to offer, but not in the applicants' area of choice." It was generally conceded that the more rural the district, the harder it is to provide full time permanent positions. As one manager said, "There is often not enough work to create a full time position."

---

[18] Several instructors in the College of Nursing, University of Saskatchewan, including Yvonne Brown, the Dean, have reassured me that LPNs are given credit for their post secondary studies and that efforts are made within the NEPS program to bridge them.

This frustration extends beyond the availability of full time positions. One manager lamented that, "SEIU has call in by seniority so the newer casuals can't get enough work." Another noted that a new casual nurse often cannot accrue enough hours to keep her license with the SRNA current. Where call in by seniority is not entrenched in the collective agreement, some districts have guaranteed a certain number of hours to new casual employees. For example, one district guarantees casual RNs that they can work 90 hours every 6 weeks or more if they wish[19]. In spite of this, several reported that new graduates and out of province registered nurses are very reluctant to relocate without the security of a permanent position.

Several management teams lamented their inability to use anyone other than casual employees to fill in for others taking leave. One manager explained, "The 28 day master rotation must be posted 40 days in advance. So if someone calls in sick, you can't fill [the vacancy] with a permanent full timer, unless your facility or town is big enough to have a floater all to itself."

Lay off provisions were another problem for some managers. It was widely argued that provisions which bump nurses in or out of specialized areas are dysfunctional. The need to train nurses in specialty areas takes time and the nurses involved are not necessarily eager to work in those areas. This is particularly frustrating when there may be other nurses who are already competent in an area, but don't have the seniority to be placed there. Many times, the researcher was told, "A nurse is **not** a nurse, is **not** a nurse" denoting that we need to recognize the differing competencies and specializations that develop over a career.

Some managers questioned the commitment of unions to solving the problem of shortages. One cited the example of a union refusing to consider recognizing the seniority of out of province applicants.

Many managers spoke of the difficulties of implementing the terms of collective agreements. Each organization operates with several bargaining units, whose members often work in the same environment, but enjoy different hours, wages and working conditions. One manager noted, "There are too many grey areas in the collective agreements, they cover different workers, are hard to manage and have given too much away in terms of management rights." Several managers noted that the labour climate is poor, especially since the strikes of 1999.

Several management teams speculated about what they would change if they could re-negotiate collective agreements. One common response was that, "Knowledge, skills and ability would be considered before seniority." Several noted that clauses regulating scheduling and hours of work were difficult to work with. For example, one manager explained that, "We can make a multi-facility posting now, but we still have to tell [employees] when they will work 6 weeks in advance. That's OK to cover people on vacation and EDOs[20] but not for family or bereavement or sick leave." Another manager explained that this sort of requirement made it very difficult to convert part time to full time jobs and reduce reliance on casual employees.

---

[19] The Director of Human Resources explained that guarantees of 112 hours in a six- week period would convert the position to permanent part time and would then have to be offered according to seniority. The manager denied that the district was trying to avoid converting employees to permanent status. "Because of our overtime situation, we could hire five RNs tomorrow without a problem, if we could only get them."

Several managers commented that collective agreements are often patterned on institutional models. As one team explained it, "Institutional contracts don't work in the community setting. Home care contracts are based on an institutional model that fails in the community. All flexibility is gone and the model doesn't reflect how community based work is done. For example, on some days, the load may be high and the next low, but the 'shift system' will not accommodate it. "

One CEO expressed his frustration that there was too much conflict in a system where all parties really want to improve outcomes for patients and clients. He felt that more could be done to be co-operative. "We shouldn't be in the same bed as everyone (government, unions) but we should at least be in the same hotel."

Structuring Work

Some districts have been attempting to re-structure work so as to mitigate the effects of shortages and minimum staffing levels. Several districts now hire staff to a community or geographic area, rather than to a specific facility or program.

Perceptions of the Health Care System Environment

The structure of the health care system sometimes interferes with recruitment, retention and skill mix issues. For example, several managers pointed out that it is difficult to transfer some home care functions from nurses to aides. "We can't use non nurses in home care. If a home care aide changes a dressing, you must charge the client, but if a registered nurse does it, its free."

Other managers recognized that the health care system is complex and no one organization or entity controls all of it. Problems are multifactorial and solutions often require a co-operative spirit that is difficult to foster. "There are no quick fixes and solutions will take time."

Health system funding was suggested as a major influence on the ability to train, recruit and retain health care providers. While some acknowledged that money was not a panacea, there was acceptance that more would go a long way towards mitigating the situation. Partially, managers attributed shortages to our inability to provide wages competitive with other provinces, but additional funding would also alleviate the need to rely on minimum staffing and casual labour.. (See the discussion on page 64.) There was much concern that the 2000-2001 provincial budget would not fund collective bargaining increases.

Much criticism was levelled at the Department of Health. Many managers argued that the Department ought to be co-ordinating some sort of provincial effort or strategy for recruitment or retention, although many of these were not sure what sort of provincial initiative would work. One Human Resources Director said that, "The Department should do more HR stuff. They need more resources if they are to do co-ordination." Others accused the Department of failing to articulate a clear vision for health care and failing to exercise central leadership for health reform. Some said that the Government has failed to support districts when tough decisions need to be made or controversy erupts. One manager observed that the, "Department has been downsized to the point that it has no capacity to do research, co-ordination and facilitation."

---

[20] Earned Days Off

Frustration with the policies of regulators and Immigration Canada was also expressed. Typical of this opinion is the following statement. "There are poor reciprocal registration arrangements with other countries. For example, physicians can come for a year until they can write their Canadian exams. Nurses can't. They can't even write the Canadian exam overseas, but must come here, without guarantee of a job to write them. And immigration red tape needs to be facilitated by Immigration Canada and others to help districts recruit."

SAHO was not spared from criticism either. Many managers felt that SAHO had lost its ability to negotiate collective agreements independently and was not useful at assisting its members to administer those agreements as it once was. "We are not on an even playing field with the unions. We have 32 Directors of HR faced with the full force of unions with research staffs. SAHO needs the funding and power to match the unions' punch. More legal staff, HR support and researchers." One CEO suggested that districts must do a better job of letting SAHO know what they want. He explained that the process is still based on, "the old 400+ board model." In the old model, member organizations would write letters to SAHO describing what they want, but now there are few enough organizations that a more in-person approach is feasible. "We've given up management rights because of the old structure," he explained. "And sometimes," he added, "We let the unions push us far beyond the limits of the collective agreements." Several senior management teams concurred, admitting that sometimes this was because management did not truly understand what rights they have under the collective agreement, and sometimes because it is easier to avoid conflict. An additional criticism of SAHO is that it had evolved as a "trustee's" organization and was becoming less able to provide services and programs needed by managers.

Not all managers blamed the deterioration of management rights on SAHO and the unions. One senior manager rationalized, "It's almost impossible to manage now. The contract makes it so expensive… Some of the provisions are unreasonable. The union reps say, 'so what? You signed the collective agreement, now you have to live with it.' And they're right! We did sign it."

Another systemic determinant of recruitment, retention and job satisfaction was the uncertainty over possible system restructuring. "Why should someone pursue a career in health care or stay in the professions," mused a CEO, "when they are unable to know if the facility [they work in] will even exist tomorrow?" Another wondered about, "The climate in health care. We don't have a sense of where the system is going, whether facilities / programs will exist in a year, whether there will be major cutbacks with resultant layoffs…" "The economy is unstable… The health care system itself is unstable," suggested another. One senior manager observed, "We need to work on removing the axe hanging over people's heads — as long as the fear is there, it turns to hatred."

The underdog mentality

One of the most frequent observations regarding job satisfaction was that health care workers seem to suffer from an "underdog mentality". Over and over managers expressed their incredulity over this phenomenon. "Health care has an underdog mentality. It may once have been true that health care workers were underpaid and poorly treated, but this is no longer true. Yet health care workers still claim they are hard done by." "If the union and the media tell you you're in wrack and ruin, you must be!" exclaimed a CEO. "Health care workers have an 'underdog' mentality. 'We are poorly paid and no one respects us.' The reality is that we actually pay quite well and have good working conditions." Commenting specifically about registered nurses, one manager mused, "Nurses talk down their own profession. 'We provide care that's just lousy' they'll say. No other profession does this." A senior nurse manager stated, "We eat our young."

Some of this attitude transferred to others. "Pessimism is pervasive and that makes it hard to recruit and retain," said a vice president of human resources. "The public's perception of management is very negative," said another.

Education

As noted above, managers have concerns regarding the education of special care and home health aides. These concerns are documented on page 69.

Many managers expressed the opinion that an important solution to shortages is to increase the capacity of College and University programs. Additional nursing and physical therapy seats as well as the creation of occupational and speech therapy programs were often suggested. At least one manager recognized that there are some limitations to the ability of class increases to be effective: "Doubling the number of nursing seats only works if the other provinces follow."

Much frustration was expressed regarding cutbacks at the Universities which have affected, not only the output of graduates, but the ability of the Universities to serve as resources for health districts. "Universities used to be of help [in helping with HR solutions], but they have been cut back too."

There was a concern that geographic proximity to the University of Saskatchewan gave Saskatoon District Health an advantage over other health districts. One example of this was the comment of a senior manager regarding NEPS. "NEPS favours recruitment for SDH because there are more students there and the clinical practicums are in Saskatoon. Grads end up gravitating to Saskatoon." Regina and other large communities share this advantage according to some rural managers: "Education is not 'user friendly' and concentrated in the cities."

Many managers insisted that bursaries in exchange for a commitment to either stay in Saskatchewan or to practise in a rural environment are needed to relieve the recruitment situation. These bursaries could be granted to students at Saskatchewan and other provinces' post secondary institutions.

Chapter

7

What we Learned

Recommendations for Change

Preamble

The ultimate goal of Health Workplace Opportunities, Resources and Challenges for Saskatchewan (Health WORCS) is to improve the quality, access and cost of health services provided to the people of Saskatchewan. Satisfied providers who wish to remain in their positions or obtain employment in Saskatchewan are crucial to achieving these ends.

One key to the success of Health WORCS depends on its ability to generate research and analysis that is of benefit to its users; and ultimately to the users of the health care system. The ability to **conduct** research into an area is not sufficient justification to **do** research in a given area.

The primary users of Health WORCS's output are:

- makers of public policy, but also include
- health system managers and decision-makers,
- unions and
- clinical decision-makers.

The ultimate impact on patients and clients must be felt in terms of:

- outcomes,
- quality,
- cost,
- access and
- use of care.

Health WORCS has striven to understand what policy makers want from research in order to do their jobs. We have constantly asked ourselves how to produce research and analysis that will apply to policy makers and how best to communicate our findings to our stakeholders.

Research all too often serves only to limit policy options by pointing out negative consequences of policy choices. While this is a legitimate function of research, we have tried to expand policy options by providing information to policy makers.

Another value that we have embraced is: If Health WORCS's research and analysis is to be useful to policy makers, care must be taken to 'get it right'. A high premium was placed on the quality of Health WORCS's findings. We have chosen to communicate only when we believe ourselves to be correct. Integrity is Health WORCS's most important asset. We have attempted to be straightforward and accurate in reporting the perceptions of all the stakeholders who have been the subjects of our research. Stakeholders may not always like our findings, but they will be unable to accuse us of favouritism or deceit.

Findings

There is often a "disconnect" between front line provider's objective experiences of work and their subjective state of morale or dissatisfaction. In other words. Providers report themselves to be simultaneously satisfied and dissatisfied. A superb example of this was a Registered Nurse who asserted very strenuously that she saw herself as an acute care nurse. She continues to harbour a great deal of resentment because, in the early 1990s, she had been bumped out of her full time acute care position into a part time position in long term care with casual shifts in home care. She declared her intention to eventually return to acute care nursing. Several minutes later, this same individual was musing about what aspects of her work she found the most rewarding. She identified her home care work and noted her clinical independence and the huge impact she had upon her clients' quality of life. This disconnect may be explained by Herzberg's theory of motivation (discussed on page 27) which explains motivation as being composed of two factors, satisfaction and dissatisfaction. This particular nurse found her home care work particularly satisfying because of the intrinsic rewards it offered. She found it dissatisfying because of the involuntary nature and capriciousness of bumping according to seniority that occurred during the time of district formation and re-adjustment.

The anger that providers feel regarding their treatment during the days of change in the 1990s extends to government, management and their unions.

Front line providers find themselves overwhelmed and identify non-patient care activities as being their greatest bane. They spend a lot of time attending meetings, doing paperwork, learning new technologies, orienting and mentoring new staff, and, especially irksome, doing clerical, reception, and even housekeeping, cleaning and maintenance activities.

"Muddling through" — or incrementalism as it is more usually labelled — is and ought to be the usual method of policy making.
Charles E. Lindblom, Political Scientist (1979)

Managers, on the other hand, have taken great efforts to keep as many hands at the bedside as possible. They have also pursued minimal staffing strategies. This strategy may or may not have been planned. It may have had its origins in 'muddling through' as Lindblom (1979) would describe it or in what Henry Mintzberg (1987) calls "emergent strategy." It is not surprising that one result has been that, "When others are busy the work gets downloaded onto front-line workers."

Ironically, both the providers, who are unable to devote as much time to direct patient care as they would like, and their managers, who have tried to preserve clinical and diagnostic positions in the face of fiscal constraint, are attempting to maximize the caring that health care services provide. The first casualties have been supports. What has been missing from the equation is an examination of what activities front line providers ought (and especially, ought not) to be doing. Both managers and providers have been constrained by the stovepiping[21] of clinical competencies that is accepted as a given in health care.

Strategy is *consistency* in behavior, *whether or not* intended.
Henry Mintzberg, Professor of Management(1987)

The effective management of a highly mobile workforce possessing scarce skills requires the commitment of a variety of stakeholders. The set of effective strategies are not within the purview of a single employer, a single government department or within the health care sector as a whole. We are paying the price (or will shortly begin to pay the price) of skill shortages in terms of greater intra-sectoral competition, deterioration of access to and quality of services and the cost of providing health services. The very existence of some rural services, programs and facilities is being jeopardized by a scarcity of labour.

---

[21] Stovepiping describes groups of activities which are segregated and in which no cross-over is permitted

Another difficulty in formulating recommendations that are useful to policy makers and providers is, while appropriate responses must be applied at a systemic level, incentives to organizations place them in a competitive situation.

Conflict

There was a certain amount of conflict found in all the relationships. Both front line and senior managers noted that many work sites are characterized by an atmosphere of confrontation, especially since the strikes last year. Several managers said they believe there is a general feeling of discontent with working conditions among the staff.

While there was a great degree of respect for individual managers and union officials, unions and managers often displayed misunderstanding and frustration with each other. Some unions suggested managers did not understand collective agreements, were inflexible and were either controlled by the government or were incapable of acting independently. Some managers suggested that unions were inflexible and did not have the interests of their members or the public as priorities. It should be noted that data were collected immediately after a series of health care labour disruptions and that the labour relations atmosphere could be described as tense.

Recommendations

1.0 General and Broad-spectrum Recommendations

In accordance with the findings of the Conference Board of Canada, we believe that:

1.1 Saskatchewan Health must assist districts and their affiliates to develop strategies for attracting top talent including: augmenting student programs; providing a learning environment; using anticipatory hiring practices; and, involving employees in the hiring process.

1.2 Saskatchewan Health must assist districts and their affiliates to develop strategies for keeping employees including: holding managers accountable for retention; having a mechanism for identifying high-potential employees; having a clear understanding of the needs and values of employees; and having effective succession management systems.

The magnet hospital literature suggests that nursing leadership is key to successful retention and recruitment

1.3 Saskatchewan Health, Health Districts and their affiliates must develop senior nurses who can manage in a style consistent with magnet hospitals. This implies nurse managers who are visionary, enthusiastic, supportive, and knowledgeable; who maintain high standards and high staff expectations; who value education and professional development, who uphold positions of power and status within the hospital, are highly visible to staff nurses, are responsive and maintain open lines of communication and are actively involved in provincial and national professional organizations.

1.4 Organizational attributes common to magnet hospitals that need to be emulated in Saskatchewan are highly placed nurses within the management hierarchy, flat organizational structures with a few supervisory personnel, rather than a pyramid structure composed of many layers, decision making that is decentralized to the unit level, giving nurses on each unit as much discretion as possible for organizing care and staffing in a manner most appropriate to the needs of their patients. Administrative structures must support the nurses' decisions about patient care and good nurse / physician communication must be fostered.

2.0 Communication

One of the themes we heard from both management and providers was a perception of a lack of vision and leadership from government. Our discussions with government, however, lead us to believe that there is such a vision for the direction of the health care system. We are forced to conclude that there are problems communicating this vision to people within the health care system.

Where there is no vision, the people perish...
Proverbs 29:18

2.1 An internal marketing mechanism must be established to continually assess the needs of people who work within the health care system and to articulate and disseminate a vision for the direction of the system that can be embraced by those charged with delivering programs and services

Saskatchewan Health is the custodian of the publicly funded health care system and, as such, shares a crucial role in overall human resources planning. While much action directed at improving job satisfaction, retention and recruitment must fall on the shoulders of Health Districts and their affiliates, no set of solutions can be embraced without the co-operation and encouragement of the Department. Furthermore, much of the dissatisfaction that we discovered amongst providers derives from history and is not easily amenable to redress. There is still a great deal of anxiety regarding possible new change within the system.

2.2 No substantive systemic reform should be undertaken in Saskatchewan without a clearly thought out, well defined and agreed upon labour readjustment strategy. This strategy must be agreed upon by Saskatchewan Health, the Districts and the Unions and it must be publicly articulated to minimize angst.

Part of the difficulty of the health provider supply problem is the competition posed by other sectors of the economy. Women, in particular, now have much greater choice in career choices and are no longer restricted to those occupations that are traditionally female dominated. People must be encouraged to enter health care occupations and professions.

2.3 A national campaign to increase the public's awareness of health care provider careers should be undertaken. This recruitment campaign must be national in scope, sustainable over the long run and directed at men and women who are at the age of post secondary education choice.

3.0 Education and Training

We found varying availability and cost associated with Aide training programs as well as scepticism as to the quality of the programs by managers.

3.1 Courses for special care and home care aides should be offered jointly by SIAST, aboriginal educational institutions, or other educational institutions with health districts or SAHO as full partners. Tuition rates should be uniform and affordable regardless of the geographic location in which the course is offered.

Much provider discontent was founded on the loss of front line managers and the relative lack of managerial knowledge and skills of those people.

3.2 Ongoing collaboration between the Department of Health, SAHO, employers and the universities is essential in order to develop management training programs for front line managers.

Doug Elliott's (1999) analysis concluded that we need between 130 and 400 seats per year in NEPS and 80 and 160 seats in SIAST's LPN program (if we do not attract nurses from outside Saskatchewan). NEPS currently has 260 seats and SIAST is enrolling between 128 and 132 per year (Frederick, 2000).

3.3 The present number of seats in the NEPS and the SIAST Practical Nursing Program should be increased as the resources of SIAST and the University of Saskatchewan permit. Funding should be allocated to facilitate this expansion. Saskatchewan should encourage other provinces to likewise increase their seats.

3.4 Saskatchewan Health has recently moved to encourage former RNs, RPNs and LPNs who have left the profession to re-certify by contributing towards their tuition costs. This is a laudable approach and the Department should continue to pursue this and similar strategies.

3.5 As part of the funding for health districts, Saskatchewan Health should allocate, according to its population/needs formula, specific funding for continuing education of licensed and self regulated providers who are employed directly by health districts. Similar funding should be made available to address the continuing education needs of unlicensed providers such as aides and technicians. This funding should include sufficient money is available to attend, and paid time off for, professional development.

3.6 The Provincial Health Human Resources Council[22] (HHRC) will assess the number of educational seats available in all health disciplines relative to system need and develop strategies to ensure appropriate clinical placement opportunities for students at both the undergraduate and post graduate levels. The HHRC will also assess the uses and need for advanced practice nurses and develop strategies for their education and/or recruitment. Over time, this role of the HHRC will be expanded to include other provider categories as needed, such as physical therapists and midwives.

4.0 Interprovincial, Regulatory, and Licensing Issues

The problem of skill shortages is a national one.

4.1 Saskatchewan Health must enlist the support of the federal, provincial and territorial governments to establish a Health Human Resources Council (HHRC) to identify strategies and methods of supporting better human resource planning with emphasis on recruitment, retention and appropriate utilization of skills.

4.2 An analogous HHRC body must be established at the provincial level to do similar work in Saskatchewan. While the Department should retain control of the agenda, membership should include representatives of SAHO, unions, regulators and the Universities and SIAST. HHRC should concentrate on (but not be limited to) strategies pertaining to workplace plans that contribute to job satisfaction, effectiveness, the full utilization of skill mix, increasing the proportion of permanent full time and permanent part time positions and ensuring adequate supply of providers from educational institutions.

---

[22] See Recommendation 4.1

At present, international nursing graduates must travel to Canada before taking the examinations necessary to practice here. This entails going through visa acquisition and all the other expenses and commitments necessary to emigrate without assurances to the nurses or the employers that they will be permitted to stay.

4.3 Saskatchewan should work with the SRNA, RPNAS and other provinces to ensure that international nurses can take the Canadian licensing examinations overseas. Alternatively, an accommodation, similar to the Medical Professions Act's Provisional Licensure[23] may allow international nurses to come to Saskatchewan and have 5 years, or another period deemed appropriate by the SRNA or RPNAS to successfully write the Canadian exams.

One of the difficulties in doing this sort of project is the assessment of how serious the labour shortage actually is. One difficulty is the ability to track individual providers who are members of this highly mobile workforce.

4.4 All licensed providers should be assigned a permanent identifier upon first licensure in Canada, which will follow them from province to province throughout their professional lifetimes. While mobility information should be available to regulators and researchers, appropriate privacy of information rules should be developed parallel to this system

5.0 Supports and Incentives

Participants of the discussion groups were able to articulate their needs and values. They resented performing work they did not consider to be 'theirs', lacked equipment and supports, identified people issues in the work environment including staff composition and organization, and opportunities for peer interaction, wanted to adjust their hours / work status according to individual need and lacked professional development

5.1 Systems to facilitate an ongoing understanding of the needs and values of employees is an essential part of retaining them. It is the employer's obligation to understand these needs and values, but these are both local and universal in nature. SAHO (at the provincial level) and Health Districts and their affiliates (at the District level) should establish ongoing working groups, to explore, research, analyze and make recommendations. While membership of these groups might contain managers and union representatives, at least one half of the membership should consist of front-line providers with no management or union responsibilities.

---

[23] See Sections 29(1) and 29(2) and bylaw 21(4)

The desire to work casual, part time or full time was often linked to individual needs, family-work balance and career stage.

5.2 Retention strategies must be tailored to the life-cycle stage of employees.

Discussion group participants said individual health districts need a strategic recruitment plan that is a part of a provincial plan for recruitment for Saskatchewan. Specifically, discussion group participants told us, to attract new people to work in the health districts,

5.3 To address *recruitment challenges*, Health districts have to offer job security; address issues of pay equity; provide incentives such as moving expenses or signing bonuses; demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, and paid time off for, professional development; and sell potential employees (and their spouses) on the job and on the community.

Discussion group participants told us that districts have to address job security concerns and attend to employees' workplace concerns about workload, work tasks, burnout, and the effect workplace issues are having on patients.

5.4 To address issues of *retention and job satisfaction*, health districts need to show employees they are valued; they need to treat them with respect; and they need to treat them like professionals. They also need to build organizational commitment among their employees by involving front-line staff in planning and decision-making; by creating and supporting opportunities for professional development and growth; and by showing their appreciation to those on the front-line.

Professional isolation from peers was an issue, particularly in rural areas. Providers who had been devolved from Saskatchewan Health had a system for meeting regularly.

5.5 It is recommended that a formalized system of peer support be established for occupational therapists, physical therapists, and community health nurses. This network should include regular case conference consultation with teams of providers as well as regular continuing education conferences.

5.6 Incentives to become front line managers must be improved so more providers will aspire to management positions.

The best way to inspire people to superior performance is to convince them by everything you do and by your everyday attitude that you are wholeheartedly supporting them.
Harold Geneen,
CEO, IT&T
Managing
(Doubleday, 1984)

At the beginning of Chapter 5, we noted Herzberg's two factor theory of motivation. It became apparent during the discussion groups that front line providers embraced those parts of the job which were directly related to patient care, even when those tasks were disagreeable. They also spent the first part of most groups discussing how much they enjoyed their jobs, especially those aspects that had a great deal of impact on improving the lives of those within their care. What dissatisfied them were what Herzberg called the 'hygiene factors'. Phrased differently, they said they derived the most satisfaction in their work from providing quality patient care. Dissatisfaction stemmed from their inability to provide quality care consistently.

Nurses are the group most often cited as being dissatisfied with working conditions. They are most likely to link collective bargaining with professional activism and they are the group that is most likely to secure media interest. The American senator, Lawson Chiles summed up the difficulties in motivating nurses in his February 16, 1988 remarks in the U.S. Senate:

> "Professional dissatisfaction... results because the specialized abilities of registered nurses are... not fully utilized. Under current management practices... nurses are often inhibited in their ability to provide high-quality, cost effective care because they are required to perform non-clinical, non-nursing-related tasks"

The same could be said of other professional providers.

5.7 Work should be organized to equip providers with the necessary supports to do their jobs. This includes such things as adequate office and filing space, ward clerks, porters, receptionists and physical equipment and supplies. As much as possible, tasks relating to clerical or maintenance work, the co-ordination of non clinical activities or paper work not directly related to clinical obligations or expertise should be done by someone else.

6.0 Skill Mix and the Structure of the Workplace

In our discussions with managers and providers, it became apparent that there is a serious distribution problem in health human resources. Generally speaking, the more rural or isolated a program or facility, the more difficult it is to retain sufficient staffing. This rule is operative even in times of provider surpluses. Even where an alternative provider could provide a service of equal quality, there will arise situations where the alternative provider is not available either.

> 6.1 Shortages of providers or problems with distribution to rural areas will be an ongoing problem with unpredictable seriousness. A range of responses will become necessary depending on how critical the situation becomes. The amount of responsibility given to providers must depend on several factors. Where shortages of the most qualified providers occur, there are two choices.
>
> a) Cease to provide a given service locally and move that service to a larger community, or
>
> b) Provide a different level or mix of services by different providers to the same or a different group of clients.
>
> Decision making will depend on how acute provider shortages become and on what degree of risk a community is willing to accept. Communities must have all the necessary information available if they are to understand, participate in and embrace decisions.

While there is some evidence to suggest that Canada will be experiencing a growing nursing shortage in the future, other evidence suggests that Saskatchewan has faired relatively well. Even if the province does not undergo a severe shortage of nurses in general, there is little doubt that part of any problem will involve unsatisfactory distribution of available human resources. The evidence regarding the quality of care provided by Registered versus Licensed Practical Nurses is unreliable. Certainly, it can be concluded that:

> 6.2 Licensed Practical Nurses are under-utilized in Saskatchewan. The best use of these independent providers is as members of a care team working with RNs or RPNs and other providers in a way that will maximize appropriate skill mix. There is no question that the appropriate use of LPNs is safe. As a principle, Licensed Practical Nurses ought to be utilized to the fullest extent of their competencies in the context of a health care team. Efforts must be undertaken to upgrade all practising LPNs to the same level, including medication and catheterization certification.

> 6.3 Registered Nurses and Registered Psychiatric Nurses are under-utilized in Saskatchewan. In fulfilling their role as providers of patient care, they must exercise leadership within a care team, working with other providers in a way that will maximize appropriate skill mix or as providers of primary care in community settings. Emphasis on leadership functions and the full employment of their scope of practice and competencies is essential. Organizational supports, which will allow them time away from

> direct patient care duties, to facilitate their full participation within the care team, such as conferencing with other team members is part of their role.

Many of the regulators, unions, management teams and front line providers brought up the issue of skill mix and told us how many provider categories were either under-utilized or inappropriately utilized. We seem to hesitate to violate occupational stovepipes or fall back on an argument which has us using the most qualified, even an over-qualified, provider to deliver a given service. We do this even when there is evidence that another provider is perfectly prepared and capable of providing the same service.

It is easy to argue that, in situations of shortage, it is acceptable to use a 'second best' alternative even if some deterioration in quality is inevitable. We have concluded, however, that there are many opportunities to free up more qualified providers, or differently qualified providers, and the resources they imply by expanding the scope of practice of others. Engaging in such practices will improve the flexibility of the system, allow for better planning and improve the quality of patient care. We can find no reason why, for example, emergency medical technicians cannot fulfil some functions in emergency rooms, or why the roles of physical therapists and nurses must be segregated to the extent that they are.

Many of the arguments we heard regarding 'de-professionalisation', the use of aides and assistants and other differently qualified personnel had merit. We need to avoid the **inappropriate** allocation of responsibilities to providers, but there is a certain amount of turf protection that tends to accompany these arguments as well. We need to sort out the true risks and benefits, put aside sectoral interests, fully integrate all providers into the health care team and fully utilize them.

> 6.4 Many health providers are under-utilized. Saskatchewan Health, Health Districts and their affiliates need to constantly explore and exploit opportunities to use providers in the most appropriate ways and to fully integrate all providers into the team. While not advocating recklessness, Health WORCS also discourages turf protection.

Saskatchewan suffers from a lack of clinical nurse specialists prepared at the post-graduate level. The Canadian Nurses Association recommends that advanced practice nurses have at least a masters level degree (Nield 1999).

While shortages exist among health care providers, such shortages are not uncommon in other economic sectors and are comparable to those for skilled people elsewhere. Nonetheless, skill shortages are a threat to health care and may jeopardize some programs and facilities.

Many nurses reported a desire to stabilize their work lives which are subject to weekends and shift work.

> 6.5 Two new categories of workers should be established: Weekend Worker and Night Worker for all three classes of nurses as well as special care aides. Terms should be negotiated to provide special monetary incentives to work weekends an/or nights exclusively. For example, the Ontario Nurses

Association collective agreement establishes a new category of weekend worker. These nurses work an average of 30 hours per week and are paid 37.5 hours

In order to facilitate the recruitment of new graduates and providers from outside Saskatchewan:

6.6a Full time positions need to be created and offered to new grads and out of province applicants. Seniority of providers from other provinces needs to be transferable, even if the courtesy is not reciprocated. More flexibility must be built into the system so that people may opt for full time or part time work according to their needs.

6.6b If employers are to wean themselves from dependence on casual labour, they and the unions must negotiate more flexibility in terms of their ability to select appropriate candidates for vacant and new positions.

Employers often identified collective agreements as the single most important barrier to recruitment and retention. Seniority clauses were the most often cited barrier to providing graduating and out of province applicants with permanent full time positions. It was generally felt by management groups that management rights had deteriorated to the point that they felt helpless to manage. Both union and management groups agreed that managers often do not have a complete understanding of the collective agreements. Nonetheless, there have been several examples of unions and employers working together to be creative within the framework of collective agreements.

6.7 SAHO must enhance training for all levels of managers so that collective agreements are understood and managers are able to effectively manage within them. This should include, but not be limited to, understanding progressive discipline and creative problem solving.

6.8 Unions and SAHO must engage in frank and open discussion as to whether collective agreements present recruitment and / or retention barriers. They must work together to create collective agreements which enhance the ability of the health care system to have adequate human resources. This discussion might include such strategies as interest based bargaining.

6.9 Unions, Districts and their affiliates need to continue to pursue creative solutions within the framework of collective agreements to better satisfy client needs.

7.0 Further Research Needed

The research conducted for this report by Health WORCS is exploratory in nature and by no means provides definitive answers to a very complex situation. Research is needed to come to a better understanding of job satisfaction, retention, recruitment and especially skill mix.

Some specific research problems of greatest import and or practical value are:

Staffing to minimize economic inefficiency has become commonplace in health care, but may be leading to inefficiencies that are not readily quantifiable. The report discusses the tendency to use the absolute minimum number of providers in the interests of economic efficiency. Dissatisfaction and quality deterioration may be caused by operating close to maximum capacity.

7.1 The philosophy of minimal staffing needs to be re-examined. Research to establish the effects on job satisfaction, retention, recruitment and client/patient outcomes of minimal staffing must be undertaken.

During the tenure of the Health WORCS project, it became apparent that a good deal of research was being undertaken by, or in conjunction with university and government researchers. Often, the work pursued similar objectives and might have been better designed to complement that of other research teams.

7.2 It is recommended that a provincial clearinghouse for research on Health Human Resource strategies be established to track and co-ordinate research activities. Saskatchewan Health should work with its provincial, federal and territorial counterparts to create a similar mechanism for identifying, sharing and disseminating health human resources research nationally.

7.3 There have been several meetings between the Department of Health, SUN and several health districts regarding a pilot project in which providers and management would be given a great deal of latitude in designing work. Such endeavours are to be strongly encouraged in an effort to identify innovative solutions to human resource issues.

There are different perceptions regarding the workload of health providers. Providers reported that part of their concerns derive from a view that there are expectations placed on them to do work that is not "theirs", that there is limited access to necessary equipment and a lack of ability, resources or flexibility to add a provider to a shift on days when the workload approaches unreasonable proportions. Conversely, much frustration derived from a lack of workload measures sensitive to a regionalized system and flexible skill mix.

8.4 It is recommended that a provincial research project be established to develop workload measurement tools appropriate to the Saskatchewan context, beginning with tools for institutional acute and long term nursing care. Such a research project should be lead by experienced researchers and should work closely with health districts and affiliates, unions and regulators.

8.0 Northern Issues

If rural areas have greater difficulty attracting and retaining health care providers, it seems intuitively obvious that northern and remote areas would have equal or greater challenges to face. The original research design included conducting several discussion groups with providers in northern Saskatchewan, including one 'virtual group' using the telemedicine technology. Unfortunately, these groups had to be cancelled. One site visit was made, to Laloche in the Keewatin Yathé Health District. Dr. Backman interviewed several registered nurses, a facility manager and a senior manager and had a tour of the town, the hospital, the home care office and several employee housing units. The major challenges faced in that community are adequate housing, the quality of education for employee's children, and the unavailability of child care, especially for shift workers. Certainly the housing situation is critical. Some providers sleep in construction trailers. As many as four (including spouses) share small two bedroom apartments. "Bachelor" accommodations are unreasonably cramped. Employees who are local to the community often have even worse housing. While a one day tour and series of interviews in one town are hardly adequate to allow for comprehensive recommendations for retention, recruitment, and job satisfaction for the north, they are adequate to recommend that:

8.1 As part of the construction of the new hospital in Laloche, additional housing dedicated to staff be constructed.

Chapter 8

References

AIKEN L, H. Smith & E. Lake (1994). "Lower Medicare Mortality among a set of hospitals known for good nursing care" Medical Care 32(5) 771-87

AIKEN Linda H., Donna S. Havens & Douglas M. Sloane (2000). "The Magnet Nursing Services Recognition Program: A Comparison of Two Groups of Magnet Hospitals" American Journal of Nursing, 100(3) 26-34

AMERICAN HEALTH CONSULTANTS (1995). "Diluting the Skill Mix: Are Nurses, Patient Care Really Threatened?" ED Management, 7(7), 73-76.

ARMSTRONG, M. (1996). "Surgical Technologists: What is Their Proper Role." QRC Advisor, 12(7), 6-8.

BARRETT, C. and Myrick, F. (1998). "Job Satisfaction in Preceptorship and Its Effect on the Clinical Performance of the Preceptee." Journal of Advanced Nursing, 27(2), 364-371.

BERNREUTER Maxine E & Sharon Cardona (1997a). "Survey and Critique of Studies Related to Unlicensed Assistive Personnel from 1975 to 1997, Part 1" JONA 27(6) 24-29

BERNREUTER Maxine E & Sharon Cardona (1997b). "Survey and Critique of Studies Related to Unlicensed Assistive Personnel from 1975 to 1997, Part 2" JONA 27(7/8) 49-55

BLEGEN, M.A., Goode, C.J., Reed, L. (1998). "Nurse Staffing and Patient Outcomes." Nursing Research, 47(1), 43-50.

BLEGEN Mary. A. & Tom Vaughn (1998). "A Multisite Study of Nurse Staffing and Patient Occurrences" Nursing Economics, 16(4), 196-203

BUCHAN J. (1993). "Evolution and Opportunity." Nursing Standard, 7, 22. (cited in NEEDHAM, J. (1996). "Balancing Skill Mix – Future Paediatric Health Care Provision." Journal of Nursing Management, 4(3), 127-131)

BUCHAN James (1999). "Still Attractive After All These Years? Magnet Hospitals in a Changing Health Care Environment" Journal of Advanced Nursing, 30(1), 100-108

CAMERON, B.L. (1995). "Multiskilling the Health Care Worker: Some Urgent Concerns." Alberta Association of Registered Nurses, 51(1), 7-13.

CAMRT [Canadian Association of Medical Radiation Technologists] (1995). "The Challenges and Opportunities of Multiskilling in Health Care." The Canadian Journal of Medical Radiation Technology, 26(3), 100-107.

CAREY, MA (Ed.). Issues and Applications of Focus Groups. Qualitative Health Research, Special Issue, 1995:5(4)

CLAY Monica L. (1997). "An Opinion: Staff Nurses at Risk; Increasing Use of Practical Nurses" Pennsylvania Nurse, 52(3), 7

COLLINS, A.L. (1997). "Multiskilling: A Survey of Occupational Therapy Practitioners' Attitudes." American Journal of Occupational Therapy, 51(9),748-753.

COREY-LISLE, P., Tarzian, A.J, Cohen, M.Z., and Trinkoff, A.M. (1999). "Heathcare Reform: Its Effects on Nurses." Journal of Nursing Administration, 29(3), 30-37.

DEWAR Belinda-Jane and Jill Macleod Clark (1992). "The Role of the Paid Non-Professional Nursing Helper: A Review of the Literature" Journal of Advanced Nursing, 17(1), 113-120

DILLON William R., Thomas J. Madden & Neil H. Firtle (1993). Essentials of Marketing Research: Homewool Ill: Irwin

DIMON Carol (1995). "Preparing Care Assistants for the Qualified Invasion" Elderly Care 7(5) 35

EASTAUGH Steven R. (1990). "Hospital Nursing Technical Efficiency: Nurse Extenders and Enhanced Productivity", Hospital and Health Services Administration 35(4) 561-73

ELLIOTT Darlene (1995). "The Role and Use of Support Personnel", International Nursing Review, 42(2), 55-60;64

ELLIS, B., Connell, N.A.D., Ellis-Hill, C. (1998). "Role, Training and Job Satisfaction of Physiotherapy Assistants." Physiotherapy, 84(12), 608-616.

FOTO, M. (1996). "Multiskilling: Who, How, When, and Why?" American Journal of Occupational Therapy, 50(1), 7-9.

FUSZARD Barbara, Elizabeth Green, Evelyn Kujala & Brenda Talley (1994a). "Rural Magnet Hospitals of Excellence: Part 1" Journal of Nursing Administration, 24(1) 21-26

FUSZARD Barbara, Elizabeth Green, Evelyn Kujala & Brenda Talley (1994b) "Rural Magnet Hospitals of Excellence: Part 2" Journal of Nursing Administration, 24(2) 35-41

FREDERICK Louise (2000). Director of SIAST LPN programme. Personal Communication, May 10.

HANSON, C.M., Jenkins, S., and Ryan, R. (1990). "Factors Related To Job Satisfaction And Autonomy As Correlates Of Potential Job Retention For Rural Nurses." The Journal of Rural Health, 6(3), 302-316.

HAVENS Donna Sullivan & Linda H. Aiken (1999). "Shaping Systems to Promote Desired Outcomes: The Magnet Hospital Model" Journal of Nursing Administration, 29(2) 14-20

HEGLAND Anne, (1993). "A Welcomed Addition to the Rehab Team. Specially Trained Aides are a Big Plus", Contemporary Longterm Care, 16(7) 48-50

HERZBERG, F., Mausner, B., and Synderman, B.J. (1959). The Motivation to Work, 2nd ed. New York: J. Wiley and Sons.

HERZBERG, F. (1966). Work and the Nature of Man , Cleveland: World Pub. Co.

HOLZEMER, W.L. (1996). "The Impact of Multiskilling on Quality of Care." International Nursing Review, 43(1), 21-25.

HRDC Canada (2000). Welcome to HRDC Saskatchewan [online]. Available: http://www.sk.hrdc-drhc.gc.ca/menu/home.shtml April 5, 2000

Human Resources Branch (2000). 1998 Saskatchewan Health Employer Survey Report, Regina: Saskatchewan Health

JAMES, S. (1983). "The PTA Role and Function: An Analysis in Three Parts [Part 2: Use of the PTA in a General Practice Setting, A PTAs Response]" Clinical Management, 3(3), 38-39.

KANGAS, S., Kee, C.C., and McKee-Waddle, R. (1999). "Organisational Factors, Nurses' Job Satisfaction, and Patient Satisfaction with Nursing Care." Journal of Nursing Administration, 29(1), 32-42.

KIMBAROW, M.L. (1997). "Ahead of the Curve: Improving Service with Speech-Language Pathology Assistants." American Speech-Language Hearing Association, 39(4), 41-44.

KIRBY, SL and McKenna, K. Experience, Research, Social Change: Methods from the Margins. Toronto: Garamond Press, 1989.

KOCH, F. (1996). "Staffing Outcomes: Skill Mix Changes." Seminars in Perioperative Nursing, 5(1), 32-35.

KOSTOVICH Carol Toliuszis, Suzette M. Mahneke, Pamela A. Meyer & Cynthia Healy (1994). He Clinical Technician as a Member of the Patient-Focused Healthcare Delivery Team" JONA, 24(12) 32-38

KRAINOVICH-MILLER Barbara, Laila N. Sedhom, Sharon Bidwell-Cerone, Nancy Campbell-Heider, Violet M. Malinski and Elizabeth Carter (1997). "A Review of Nursing Research on the Use of Unlicensed Assistive Personnel" Journal of the New York State Nurses Association 28(3) 8-15

KRAPOHL Greta & Elaine Larson (1996). "The Impact of Unlicensed Assistive Personnel on Nursing Care Delivery" Nursing Economics, 14(2) 99-123

KRUEGER Richard A. (1988). Focus Groups: A Practical Guide for Applied Research, London: Sage Publications

LASCHINGER, H.K.S. and Sabiston, J.A. (2000). "Staff Nurse Empowerment and Workplace Behaviours." The Canadian Nurse, 96(2), 18-22.

LEWIS Patricia M. (1993). "Successful Introduction of LPNs into Critical Care Practice…Partnerships Between an Experienced RN and Nurse Extender" Critical Care Nurse, 13(6) 94-7

LINDBLOM Charles E. (1979). "Still Muddling. Not Yet Through." Public Administration Review, 39(Nov/Dec) 517-526

LUPI-WILLIAMS, F.A. (1983). "The PTA Role and Function: An Analysis in Three Parts [Part 1: Education]" Clinical Management, 3(3), 35-38.

MASLOW, A. (1954). Motivation and Personality. New York: Harper and Row.

MILES, MB and Huberman, AM. Qualitative Data Analysis: A Sourcebook of New Methods. Beverly Hills: Sage, 1984.

MINTZBERG Henry (1987). "The Strategy Concept I: Five Ps for Strategy", California Management Review, Fall, 11-24

MINYARD K., J Wall & R Turner (1986). "RNs May Cost Less Than You Think" J Nurs Adm, 16(5):28-34

MORGAN, D. Designing Focus Group Research. In, Tools for Primary Care Research. London: Sage, 1992.

MUNROE (1990). "The Influence of Registered Nurse Staffing on the Quality of Nursing Home Care" Research in Nursing and Health, 13(4), 263-270

MURPHY, Steven A. (2000). What to Do Before the Well Runs Dry: Managing Scarce Skills, Ottawa: The Conference Board of Canada

MUSSALLEM Helen K. (1968). "No Lack of Nurses – But a Shortage of Nursing" International Nursing Review 15(1) 35-49

NEEDHAM, J. (1996). "Balancing Skill Mix – Future Paediatric Health Care Provision." Journal of Nursing Management, 4(3), 127-131.

NEIDLINGER Susan H, Janet Bostrom, Anne Stricker, Janet Hild & Jian Qing Zhang (1993). "Incorporating Nursing Assistive Personnel into a Nursing Professional Practice Model" JONA, 23(3) 39-37

NIELD Sharon (1999). Advanced Nursing Practice: Where does it Fit? Conference sponsored by Continuing Nursing Education, College of Nursing, University of Saskatchewan and the Saskatchewan Registered Nurses' Association, Saskatoon, November 19.

PATTON, MQ. Qualitative Evaluation Methods. London: Sage, 1990.

PIETRANTON, A.A., and Lynch, C. (1995). "Multiskilling. A Renaissance or A Dark Age?" The Magazine of the American Speech-Language Hearing Association, 37(6/7), 37-40.

PLOETZ, P.A. and Woller, T.W. (1992). "Pharmacy Technicians." In T.R. Brown (Ed.), Handbook of Institutional Pharmacy Practice (3rd ed.). (pp. 397-401). Bethesda, MD: American Society of Hospital Pharmacists.

RAMSAY, D.L. (1995). "Position Paper: Use of Occupational Therapy Aides in Occupational Therapy Practice." The American Journal of Occupational Therapy, 49(10), 1023-1025.

REED Laura, Mary A.. Blegen, Colleen. S. Goode (1998) "Adverse Patient Occurrences as a Measure of Nursing Care Quality" Journal of Nursing Administration, 28(5) 62-69

REISDORFER Joan, Lori Pankonin & Barb Larsen (1993). "Making the Transition to Nursing Assistants: Retaining satisfied staff" Recruitment & Retention Report, 6(10) 1-5

RIGBY John M & Allen M. Backman (1999). "The Acute Care Crisis As A Capacity And Demand Optimisation Problem", Exploring the Health Frontier: The Effect of Reform Initiatives on Canadian Health and Health Care, Proceedings of the 8th Canadian Conference on Health Economics, Canadian Health Economics Research Association Annual Conference, Edmonton, August 19-21

ROGERS, J.L. (1991). "PTA Utilization: The Big Picture." Clinical Management, 11(4), 8-9.

RUSSELL, K.V. and Kanny, E.M.(1998). "Use of Aides in Occupational Therapy Practice." The American Journal of Occupational Therapy, 52(2), 118-124.

RYTEN, Eva (1997). A Statistical Picture of the Past, Present and Future of Registered Nurses in Canada, Ottawa: Canadian Nurses Association

SALMOND Susan W. (1995). "Models of Care Using Unlicensed Assistive Personnel. Part 1: Job Scope, Preparation and Utilization Patterns", Orthopaedic Nursing, 14(5), 20-30

SCOTT Joan Gleason, Julie Sochalski & Linda Aiken (1999) "Review of Magnet Hospital Research: Findings and Implications for Professional Nursing Practice" Journal of Nursing Administration, 29(1) 9-19

SHAMIAN Judith & Donna Thomson (1999). The Effectiveness and Efficiency of Nursing Care – Cost and Quality, Toronto: Canadian Federation of Nurses Unions

SIBBALD Barbara (1997). "Delegating Away Patient Safety" The Canadian Nurse 93(2), 22-26

SNELL Janet (1998). "A Force to Reckon With" Health Service Journal, 108(5599) 24-27

SPENCER, LJ. Winning Through Participation. The Group Facilitation Method of the Institute for Cultural Affairs. Dubuque, Iowa: Kendall/Hunt Publishing, 1989

SPURGEON David (2000). "Canada Faces Nursing Shortage", British Medical Journal, 320(7241) 1030

TASK FORCE ON SUPPORT PERSONNEL (1996). "Guidelines for the Training, Credentialing, Use, and Supervision of Speech-Language Pathology Assistants." American Speech-Language Hearing Association, 38(Suppl.16), 21-34.

TOVEY, E.J. and Adams, A.E. (1999). "The Changing Nature of Nurses' Job Satisfaction: An Exploration of Sources of Satisfaction in the 1990's." Journal of Advanced Nursing, 30(1), 150-158.

TULL Donald S. & Del I. Hawkins (1990). Marketing Research: Measurement and Method, 5th edition, New York: Macmillan Publishing Company

WAGNER, L. (1995). "Trends Toward Multiskilling: A Full Circle of Challenges and Changes." Access, 9(10), 16-23.

WAREHAM Elynn (1999). "Band-aids won't solve skills crisis" Technology in Government, 6(9), 13

WEISMAN Carol S. & Constance A Nathanson (1985). "Professional Satisfaction and Client Outcomes: A Comparative Organizational Analysis" Medical Care, 23(10) 1179-92

Chapter 9

Appendices

Appendix A.

Health Districts Included in Discussion Groups

Health District	Location
Assiniboine Valley	Kamsack
Battlefords	North Battleford
Moose Jaw Thunder Creek	Moose Jaw
North Central	Melfort
Parkland	Shellbrook
Prince Albert	Prince Albert
Regina	Regina
Saskatoon	Saskatoon
South Central	Weyburn

Appendix B.

Discussion Group Participants

	Number of Participants		
Group	With < 10 years experience	With 10-20 years experience	With > 20 years experience
Front line supervisors	1	7	20
Nurses	13	29	35
Aides	15	13	3
Therapy OT/PT Speech/Respiratory	18	5	9
Technicians	9	7	10
Other*	23	13	8
All	79	74	85

* Includes among others, public health inspectors, dental health educators, needs assessment co-ordinators, social workers, psychologists.

Appendix C.

Participant Consent Form

Health Workplace Opportunities,
Resources and Challenges for Saskatchewan
Discussion Group on Job Satisfaction, Recruitment,
and Retention in Saskatchewan Health Districts

PARTICIPANT CONSENT FORM

Health WORCS is an independent research initiative commissioned by the Saskatchewan Department of Health to conduct research on health human resources issues in the province. The Health WORCS project is led by Professor Allen Backman, PhD, of the University of Saskatchewan. Our job is to research the work of health care providers and the care they give. We are currently doing a study of the issues that affect Job Satisfaction, Recruitment, and Retention in Saskatchewan Health Districts. This phase of the study involves three pieces: Small group discussions (similar to focus groups) with groups of front line health care providers (separate groups with supervisors); key informant interviews with senior management teams, unions and regulatory bodies; and the solicitation of written submissions from districts, affiliates and other stakeholders.

We would like to invite you to participate in a small discussion group about your workplace experience. If you agree, we will be asking you and approximately 8 - 12 other people from your district questions about your experiences at work and how they affect your job satisfaction; the factors that might make you decide to stay with or leave a job; and what factors might attract you to take a health care job. This group discussion should last about three hours.

You are free to decide to be in this study. Your decision, whether yes or no, will not affect your job in any way. You can refuse to answer any of the questions put to you throughout the course of the research. Likewise you can withdraw your participation from the research at any time. If you choose to withdraw from the group discussion, any information we have collected from you will not be used.

All information gathered for this study will remain strictly confidential. We will not pass on anything you say to your employer or any one else in a manner in which you might be identified. All information will be securely stored and be kept for a minimum of 5 years. The results of this study may be presented to interested people through publications or presentations. Again your identity will not be revealed in these presentations. We will use the information only for health research.

Should you have any questions or concerns regarding the research procedure or confidentiality, please bring them to the attention of the group facilitator immediately. If you agree to participate in this research, please sign and date this form.

The researcher responsible for the small group discussion component of the study is Joanne Hader, Senior Research Officer with the Health Services Utilization and Research Commission in Saskatoon. She can be reached at 1-800-655-1599. If you have any questions about the larger research project or about Health WORCS, please contact:

Dr. Allen Backman
Health WORCs Project
C/O Saskatchewan Health
122 – Third Avenue North
Saskatoon, SK S7K 2H6
1-306-933-6236

If you agree to be in this study, please sign below.

Please place your initials in this space _____ to indicate that a copy of this form has been made available to you for your records.

I am eighteen years of age or older. I have had this study explained to me and have read, or have had someone read to me, the above information.

I understand that:

☐ I will respect the comments of the others participating in the group as confidential;
☐ No one outside the research team will have access to the list of names of those who participated in the research;
☐ The researchers may use explicit quotes for their research but will not identify who said them;
☐ My identity will not be revealed in any publication or report the researchers produce; the community may be named;
☐ My employment will not be affected by my participation or lack thereof in this study;
☐ I can withdraw from the study at any time;
☐ I will have the opportunity to listen to the taped transcript of this group discussion; and,
☐ I freely agree to be in this study and to answer questions from the researchers.

______________________________ ______________________
Signature of Participant Date

____
Signature of Witness

Please place your initials in this space ______ to indicate that you would like to review the taped transcript for this focus group discussion.

I want a copy of the report from the Department of Health, when it is done.

Please mail it to the following address:

Appendix D.

Facilitation Guide

Health WORCS

Discussion Group Facilitation Guide

Room Setup

Make the room as comfortable as possible
Distribute consent form and information sheet, paper, pens, and name cards
Make sure coffee/juice is available
Locate the washrooms
Mingle with participants as they arrive

Welcome (15 minutes)

Time started: __________

Who we are

[Facilitator gives names of those present,
Where each person is from . . .]

OUR ROLES TODAY

[All job/tasks don't have to be mentioned]

Facilitator

☐ Keep the group talking
☐ Ask some general questions and probes
☐ Make you feel comfortable
☐ Debrief after the session

Co-facilitator

☐ Handle interruptions (like people coming to the door/phone ringing)
☐ Take notes [including non-verbal communication]
☐ Tape the session
☐ Watch the time
☐ Generally help out
☐ Write things on flip charts if necessary
☐ Responsible for supplies/equipment/set up
☐ Provides feedback to facilitator about the process
☐ Responsible to summarize the session

HealthWORCS

☐ Contracted by Saskatchewan Health to identify workplace issues related to recruitment, retention and job satisfaction

Our objective in conducting the discussion group

We have been contracted to conduct discussion groups in 10 health districts in Saskatchewan. We are talking to the health care professional staff. That is, the staff that delivers hands on patient care, excluding physicians. In some districts we will also conduct discussion groups with front-line managers and supervisors.

What is it we want to know—In the discussion group, we want your help in identifying the most important issues related to the recruitment, retention and job satisfaction of health care professionals in Saskatchewan.

How participants were picked—All of you were randomly selected to participate in this group. We used seniority lists where they were available, for example from SUN, SEIU. If you are the only social worker from your district, you were randomly picked too!!! We are only going to 10 districts in the province, so we want to people we include to be 'representative' of health care professionals from throughout the province.

How the information will be used—We are going to add what we hear in the discussion groups to data Health WORCS is collecting in discussions with senior leadership in the health districts, and with union and regulatory agency representatives.

Health WORCS mandate is to provide a report on health human resource issues in Saskatchewan to the health department. They are planning to do this by the End of April 2000 of this year. In addition to summarizing the discussions, the report will include recommendations for change.

Health WORCS is confident SK Health will listen to their recommendations. They have commissioned the research because they know it is important, they know change has to happen, and they have assured Health WORCS they are committed to making change.

Consent Forms

1. Give participants a minute to look at the form (many will have seen it upon arrival)
2. Read the bottom section only, pointing out where they initial, sign etc…
3. **Ask if there are any questions**
4. Ask them to sign and initial the form and
5. Pass completed forms and information sheets to the co-facilitator

Guidelines for group discussion

- ☐ Feel free to participate or not, as far as you are comfortable with the topic. For the first question we will call on people—to hear from everyone.
- ☐ A reminder that we are taping this session. We do this in case we need to clarify something that was said—to be certain we understood correctly. Also, another researcher may listen to the tape to validate the summary of the session we write up. At no time will you or your health district or community be identified in any reports or summaries.
- ☐ Remember, what is said here, stays here. Please respect each other's confidentiality.
- ☐ We want you to be comfortable. Get up and stretch if you need to, help yourself to coffee/donuts… The washrooms, for those of you not familiar with this facility are ______.
- ☐ Remember this is a group discussion. Give others a chance to be heard. Please respect other's rights to participate and don't cut people off or interrupt.
- ☐ Please speak one at a time—if several people are talking at once the tape will not pick anything up clearly.
- ☐ If you see you are dominating the whole conversations try reigning yourself in. If you just can't, the facilitator is here to help you!!! Conversely if you are really quiet, the facilitator has a few tricks up her sleeve to use engage you in the discussion.
- ☐ We have three hours total today. And, we have several things we need to accomplish.

The Plan:

- ☐ WE HAVE ALREADY SPENT ABOUT 15 MINUTES OF OUR TIME TELLING YOU WHY WE ARE HERE AND ENSURING YOU UNDERSTAND THE CONSENT PROCESS AND HOW YOUR ANONYMITY WILL BE ENSURED.
- ☐ WE HAVE ABOUT THE NEXT 90 MINUTES TO HEAR FROM YOU.
- ☐ FOLLOWING THAT, WE ARE GOING TO POST THE ISSUES YOU HAVE RAISED, REFLECT ON WHAT WE HAVE DISCUSSED, AND HAVE ANY FURTHER DISCUSSION AS NEEDED. WE HAVE SET ASIDE 15 MINUTES FOR THIS.
- ☐ TO WRAP UP, YOU WILL BE ASKED TO DO A SMALL GROUP EXERCISE IN GROUPS OF TWOS OR THREES. WE NEED ABOUT 1/2 HOUR FOR THAT, AND ANOTHER ½ HOUR FOR GROUPS TO POST AND DISCUSS THEIR WORK FOR THE LARGER GROUP.
- ☐ WE SHOULD BE OUT OF HERE BY _______.

[In groups with aides, you may need to start the 90-minute session with a 15-minute small group exercise, identifying issues in pairs or threes before general group discussion]

Are there any questions before we begin?

TIME: __________

Restate the purpose: In this discussion group, we want your help in identifying the most important issues in the recruitment, retention and job satisfaction of health care professionals in Saskatchewan.

Participant Introductions (15 minutes)

[Co-facilitator turns on the tape recorder,
Posts the MY JOB… statement]

To begin, we are going to go around the table and have each of you say something about yourselves, where you work, and word or two about your health care experience. We would also like each of you to complete the following statement:

My job is …

Facts/Feelings (75 minutes)

Note what participants say in their introductions. **Pick one description participants have used. Follow up on this to continue the discussion.**

Enjoy my job
Am more than a nurse
Is rewarding
Has changed a lot in the past few years
Pulled in many directions
Is getting tougher
More satisfied if I just did my job
Is frustrating
Extremely stressful
Is challenging

[PROBES 1 AND 2 MAY NOT BE NECESSARY, THE "MY JOB" QUESTION
MAY MOVE PEOPLE RIGHT INTO TALKING ABOUT FACTS AND FEELING]

PROBES (USE ONLY IF NEEDED)

1. In a typical day at your job, tell us about some of the things you do.
2. When you get to work to start a shift, what are some of the things you typically do?
3. Tell me about some high points of your day.

☐ What are some of the things you like/dislike about your job/workplace?
☐ Tell me about some of the challenges you face at work.
☐ What keeps you in your job?
☐ Are your education/skills/ability used to your full potential?
☐ Are there times you feel your education/skills/abilities are not being used to their full potential? (If so, when?)
☐ Are there things in your job your have been oriented/trained to do you that you are not doing?
☐ Are there things in your job that you are asked to do that you are not oriented or trained to do?

4. Suppose you meet a young person interested in going into your profession. What would you say to them?
5. What do you think would make someone go into your profession?

PROBE (for managers only)

6. What are the major challenges and rewards of being a front line manager?

[Co-facilitator: Remind the group when there is 5 minutes left in this section]
[Before moving on to the next section, make sure to ask…]

Are there any other things you would like us know?
About Recruitment—getting into this type of work
About Retention—staying in this type of work
About Job satisfaction

Interpretation (15 minutes)

[Suggest participants stand and stretch for 5 minutes, time-permitting]

We have identified a lot of issues. ____________, the co-facilitator, has been keeping track of the issues as they were raised. She is going to post them now. What we need to do is reflect on them as a group. We need to add any we feel have not been raised or any that may have been overlooked.

[Co-facilitator posts issues,
using participants own words wherever possible.
Reads them and asks if she has captured them all, asks for more]

Time: __________

Solutions (30/30 minutes)

[Facilitator assigns groups]
[Co facilitator posts objective, and hands out post-its and felt pens]

For this exercise we have these giant post-its. We want you to summarise your group's discussion on these. We will give everyone opportunity when they are finished to share them with the other groups.

> It is your job to recruit and retain the front-line staff in your district. Knowing all the issues we have discussed today, what would you do?

PROBES

☐ IF GROUPS APPEAR TO BE STRUGGLING, THEY CAN GET THE PROCESS GOING BY ADDRESSING EACH ISSUE: Which issues are the most important to you/your group? What realistically could be done to address these issues?

Time: __________

Wrap Up

Before we wrap up, does anyone have anything else they would like to share?

Well, thank you all for coming. You have all worked incredibly hard. Hearing about workplace issues from front-line workers is really important. As we mentioned at the start on this session, Health WORCS will be submitting the report and recommendations to the health department by the end of April.

Reporting

[Co-Facilitator writes up a summary of the group
as soon after the group as possible]

A. THE ISSUES AS POSTED
b. Additional issues raised in discussion after posting/reflection and a break!
c. Solutions by group (from flip charts pages) [include some comments on who was in each group, e.g., public health nurse, acute care nurse…]
d. General Observations – about the process, from a discussion with the facilitator and any observers

Tips for facilitators:

Facilitator's goal – make people comfortable so they talk/participate

You may not have to ask a lot of questions, play it by ear

The trick in these sessions will be to move people past the issues discussion, to keep the session within the 3 hour time frame

Listen to everyone in the group equally, be careful you don't have favourites (we are all drawn to some people more than others, just being cognizant of this should help avoid this pitfall)

Remember to expect different points of view

Encourage participation with:

a. Eye contact
b. Attentiveness
c. Smiling

Remember be careful not to infer value judgements about what people say – avoid negatives AND positives (e.g., don't say 'good answer', could discourage someone with an opposing view from speaking up)

Things you can say to encourage people to talk:

d. Yes
e. Tell us more
f. Thank you for sharing that
g. Are there others with something to add
h. We want to hear all different points of view. Is there someone with a different experience?

If the group starts questioning each other don't discourage it (but if things get way off on a tangent gently pull people back in)

Discussion Groups: Categories of Analysis—Challenges to Recruitment and Retention

HOW THE WORK IS ORGANIZED

Workload

The Work Environment

- The site
- The people
- Staff Composition
- Staff Organization
- Staff and Peer Interactions
- Patients and Families

The Work Available

- Job Security
- Compensations and Benefits
- Wage Parity

HOW THE WORKPLACE IS MANAGED

- Support
- Communications
- Standards and Policies
- Contracts
- Professional Development

THE INFLUENCE OF THE EXTERNAL ENVIRONMENT

- Being Rural
- The Health Department
- The Community
- Public Perceptions

Appendix F.

Discussion Group Participants' Recommendations for Addressing Challenges to Recruitment

Type of Jobs	Offer permanent jobs vs. casual	offer more permanent full time positions	more full time opportunities	
	Perm full time	written, guaranteed hours of work	offer permanent jobs with guaranteed hours	
	job sharing permanent positions/more flexibility	guaranteed hours	full time positions, job stability	
Workplace	address working condition issues - workload, equipment		set reasonable limits e.g., caseloads	lower staff/patient ratio
	Make sure replacement coverage is in place - holidays, sick leave, maternity	wage parity	pay equity across the western provinces	the most up to date equipment to attract new grads - state of the art equipment
Incentives	offer bonuses for rural nurses	moving expenses	cover relocation costs	relocation assistance
	extended health benefits	signing bonus	benefits	signing bonus for coming to district (with two year contract)
	stay for a year guaranteed salary increase	guaranteed pay scale-know where you could be in 10 years	recruitment incentive if stay for 2 years	
Professional Development	need an education co-ordinator		offer financial support for education	professional development available and new recruits will think they have opportunity to move up
	continuous education – pd. Or free (e.g. Get a paid day per month or bank time for longer courses)	continuing ed opportunities		buddy system for new staff orientation
	In services - for all staff – on regular basis on working hours	proper orientation for new staff		
	Guarantee of further ed opportunities career development	offer rural nursing as a speciality		

Discussion Group Participants' Recommendations for Addressing Challenges to Recruitment

Advertise	need more ads for our district	honest recruitment advertising	be proactive - anticipate staffing needs and recruit before current staff vanishes	
	appropriate and adequate job advertising	advertise in papers, on the Internet, not just between facilities	send therapists to recruitment fairs	
	recruit professionals before their final year	go to job fairs	hire grads earlier	
	develop interests expertise, career	find out what potential employees want	involve staff in recruitment	
Environment	promote city: social; physical sports; resort area close	welcoming committee when recruits come for interviews	educate high school students	have a vision FOR RECRUITMENT
	change district's reputation	increase the visibility of the health professions and let people know what you do in your job	increase positive attitudes towards nursing	offer more than expected not "cheaping out" and underpay
	recruit before person leaves - change over time, and empty positions	have a broader recruitment vision	help spouses find jobs	
Education system		train SCAs on the job; train OTs in SK	bursary program	rethink education e.g., on the job
	free tuition for SK people to go into health professions	Student loans	increased access to education	bursaries to stay in community
	bursary tied to stay in SK for set time	more positions for training OTs and PTs	financial support for education	Standardized, recognized diploma

Discussion Group Participants' Recommendations for Addressing Challenges to Retention and Job Satisfaction

Value employees	value employees: pay properly; ensure breaks taken; guarantee holidays	Employee input-listen to their concerns and issues and address them	input from front-line workers on how to spend money--listen to us	more employee involvement in decisions; see results of meetings
	listen to staff input	input into the daily operation of departments		
	long term district plan involving employees	keep communications channels open - keep staff informed	value our opinions; we need to feel included to feel part of the team	give staff a sense of commitment
	keep employees trained - offer courses and that are close by; offer paid time / courses more often	treat people with respect and dignity	opportunity for growth in the job	create communications channels so employees can safely voice ideas or concerns without fear of reprisal
	more funding for continuing education	education support	more availability for training/budget	more education, paid education leave
	incentives for furthering education	paid continuing education	recognize professional dev with salary and benefits	
	permanent positions to present staff before new recruits (recruits offered ft positions before local staff)	monetary incentive to on-call staff		
	full time employment	more full time positions	more full time and part time positions	permanent hours for ft and part-time
	guarantee hours for casual staff	more security for casual staff	job sharing for people with family obligations…all kinds of staffing options	keep promises
	value appreciation and acknowledgement (even Christmas card)	acknowledge the extras people put into their jobs	genuine, sincere job appreciation	pats on the back; staff appreciation events
	more money for adequate staffing	Recognition for jobs performed	encouragement and recognition at work	performance, service recognition bonuses, name on the wall, gift certificate - you did well, you stuck it out
	more recognition and bonuses for long term employees	bonuses for long term employees		unexpected coffee parties, free parking for a month, just because
Treat Staff Like professionals	auxiliary staff doing more to free nursing time for assessing patients etc. – e.g., Bowel care, vital signs, simple treatments	recognize previous experience and education	treat employees fairly	respect from management - approachable, deal with issues in a timely manner

Discussion Group Participants' Recommendations for Addressing Challenges to Retention and Job Satisfaction

	adequate staffing levels and appropriate staffing e.g., Clerical staff ; don't give us two aides instead of one RN	full staffing	evaluate the staffing situation and hire more staff	respect from other professionals e.g., teachers, doctors
	spend more money on front-line workers	lower staff/patient ratio by hiring more staff	listen to staff about patient load	more control over workload
		Relief	mutual respect	opportunities to learn new skills
	wages both competitive and enhanced for rural employees	allow staff to do what they are trained to do	Increased Utilization of skills	use each staff to their full potential
	provisions for upgrade or purchase of equipment supplies, etc.			
	guaranteed vacation	allow staff to take holidays		
	Flex time	increased responsibility on the workplace, flexible shifts	employers need to be flexible, flex time, recognize family responsibilities	
Address Relationships	management support	managers who know what we are doing	positive supervisor	management and unions have to come together to resolve issues
	good relationships with co-workers and supervisors	unbiased ombudsman - non union, non management	peer support	mandatory management training - ongoing
			opportunities for staff interactions	
Incentives	offer bonuses for rural nurses	day care in facility	day care in the facilities	more steps in pay scale
	bonus to encourage retiring nurses to stay on one more year	benefits comparable to other professionals, SaskTel, RCMP	bonuses for seniority	good pension and benefits
Other	Professional associations support each other, members have to work together	Improve professional/discipline networking	revisit job descriptions	focus on retaining the people we have
		Identify bottlenecks in communications and IT and seek solutions	revisit decentralization e.g., community therapists	

Acknowledgements

Allen Backman of Health WORCS and Joanne Hader of HSURC gratefully acknowledge all those who participated in this adventure. In particular we acknowledge the hard work of:

- Jennifer Link, who kept Dr Backman organized, did all the up-front work with health district contacts to set up the interviews and discussion groups, ensured coffee and other amenities were ready for us when we arrived and helped with the writing process.
- Leslie Bousquet, for administrative support, advice, counsel and wisdom.
- The people in the nine health districts that we went to for discussion groups (and the district in which we did our pilot group) particularly those people who set up the meetings and found participants for us and especially all those who participated in the groups sharing with us their opinions, concerns, and knowledge.
- All the senior managers, union officials, regulators and professional association staff people who gave of their time to speak with us, prepare documents and help sort through issues. In particular, we would like to acknowledge the advice of Stan Rice, Arliss Wright, Rosalee Longmoore, Beverly Crossman, Ede Leason, Donna Brunskill, Rivi Seaberg, Dennis Kendel, George Schurman, and Shelly Chirpilo.
- Our advisory Group which consisted of Jean Morrison, CEO of the Parkland Health District, Brian Morgan, Vice President of Saskatoon District Health, Beverly Crossman, Executive Director of the Saskatchewan Union of Nurses and Angela Busch, Professor of Physical Therapy, University of Saskatchewan, who reviewed the methodology for the discussion groups and whose valuable advice steered us clear of avoidable obstacles.
- Laurie Thompson, CEO and the members of the Board of Commissioners of HSURC, Liz Harrison (Chair), Barry Maber (Vice-Chair), Jerry Danielson, Dan de Vlieger, Marianne Hodgson, Cecile Hunt, James Irvine, Bob McCulloch, Jean Morrison and Paul Peloso for agreeing to give the project the needed resources and support.
- The two contracted discussion group facilitators, Joanne Barry and Lori Hanson.
- The HSURC staff who co-facilitated discussion groups including Joanne Hader, Laurie Gander, Heather Macdonald, and Maureen Bingham.
- Dianne Ferguson, HSURC Research Transfer Officer, who was a second set of eyes both for the form and the content of the discussion group portions of the report.
- Tasha Tangjerd for unwavering enthusiasm and energy, not to mention determination in maintaining the literature database and labouring in dusty libraries.
- Kelly Kummerfield, Allan Barss and Marlene Smadu of Saskatchewan Health for their advice and guidance.
- Liz Mayor of Saskatchewan Health for all the support services she provided, not the least of which involved always knowing whom to speak to for needed resources.

- Dean V. Lynne Pearson and Professor Colin Boyd of the College of Commerce, University of Saskatchewan for facilitating the leave of absence Allen Backman needed in order to undertake this project.